ARIZONA DEPARTMENT OF HEALTH SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

COVERED BEHAVIORAL HEALTH SERVICES GUIDE

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I. Introduction

A. Purpose

The Arizona Department of Health Services – Division of Behavioral Health Services (ADHS/DBHS) has developed a comprehensive array of covered behavioral health services that will assist, support and encourage each eligible person to achieve and maintain the highest possible level of health and self-sufficiency. The goals that influenced how covered services were developed included:

- Aligning services to support a person/family centered service delivery model.
- Increasing provider flexibility to better meet individual person/family needs.
- Eliminating barriers to service.
- Recognizing and including support services provided by non-licensed individuals and agencies.
- Streamlining service codes.
- Maximizing Title XIX/XXI funds.

The impact of maximizing Title XIX/XXI funds is far-reaching. Not only will it bring more federal dollars into the state to pay for services but it also will free up non-Title XIX/XXI dollars to provide services to non-Title XIX/XXI eligible persons and to provide non-Title XIX/XXI services to all eligible persons. To maximize Title XIX/XXI funds, it is critical that Regional Behavioral Health Authorities / Tribal Regional Behavioral Health Authorities (T/RBHAs) and their subcontractors also maximize their efforts to assure that all Title XIX/XXI individuals are enrolled in AHCCCS.

In addition, maximization of Title XIX/XXI funds is dependent on claims being submitted correctly. There are three critical components that must be in place to successfully bill for Title XIX/XXI reimbursement:

- The person receiving the service must be Title XIX/XXI eligible.
- The individual or agency submitting the bill must be an AHCCCS registered provider.
- The service must be a recognized Title XIX/XXI covered service and be billed using the appropriate billing code.

These individual components are addressed in depth in this service guide.

In order to maintain the integrity of the ADHS/DBHS Covered Services Guide, a consistent process for requesting and considering changes has been developed. Requested changes, including changes to the services, the service codes, the provider types, and the listed rates, will be implemented on a quarterly basis unless the Deputy Director authorizes a change to take effect immediately. A request for change to the Behavioral Health Covered Services Guide may be made by representatives of ADHS/DBHS, the T/RBHAs or their contractors, persons and/or their families, advocates

or other state agencies. Written or verbal requests should be forwarded to the ADHS/DBHS Division Chief for Clinical Services. The ADHS/DBHS Clinical Coordinating Council will consider each request. The final disposition of any request for change to the ADHS/DBHS Behavioral Health Covered Services Guide will be communicated back to the requestor.

B. Organizing Principles

ADHS/DBHS has organized its array of covered behavioral health services into a continuum of service domains for the purpose of promoting clarity of understanding through the consistent use of common terms that reach across populations. The individual domains are:

- Treatment Services
- Rehabilitation Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Programs
- Prevention Services

This continuum not only applies to delivering services but also serves as the framework for program management and reporting.

Within each domain, specific services are defined and described including identification of specific provider qualifications/service standards and limitations. Additionally, code specific information (both service descriptions and billing parameters) is provided. Although comprehensive information is described in this guide regarding ADHS/DBHS allowable service codes; providers may want to reference the *Healthcare Procedure Coding System (HCPCS) Manual* for additional information.

General information is also provided about the use of national UB92 revenue codes, national drug codes and CPT codes, however, detailed procedure code descriptions for these codes covered by ADHS/DBHS should be referenced in the following manuals:

- *UB92 Manual*
- *First Data Bank Blue Book (i.e., pharmacy information)*
- *Physicians' Current Procedural Terminology (CPT) Manual*

C. General Guidelines

In order to appropriately utilize the array of covered services to improve a person's functioning and to be able to effectively bill for those services provided, there are a number of general principles/guidelines that are important to understand. While Section II discusses the delivery of specific services, there are overarching themes that apply to the delivery of all services, which must be understood. This discussion is divided into three subsections:

- Provision of Services
- Provider Qualifications and Registration
- Billing for Services

These guidelines provide an overview of key covered services components. More detailed descriptions and requirements can be found in ADHS/DBHS policies.

Effective January 1, 2006, Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX), must receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs).

T/RBHAs will use state funds to pay the Medicare Part D cost sharing, excluded Medicare Part D drugs, and non-covered Medicare Part D drugs for dual eligibles and behavioral health recipients determined to have a Serious Mental Illness (SMI). The use of state funds for Medicare Part D cost sharing for non-Title XIX, non-SMI recipients is based on available funding as determined by the T/RBHA.

T/RBHAs use of state funds to cover the Medicare Part D cost sharing could include any of the following:

- Premium
- Copayment
- Co-insurance
- Deductible

Billing requirements for payment of the Part D premium with state funds can be found in Section II.D.9, Non-Medically Necessary Covered Services.

Billing for payment of co-payments, co-insurance and/or the deductible will be done by using the Universal Pharmacy Claim Form. The form must indicate the amount paid by the Medicare Part D plan and any applicable cost sharing required.

Prescription drug coverage for Medicare eligible behavioral health recipients enrolled in Medicare Part D will be based on Medicare Part D plans' formularies. Benzodiazepines, barbiturates and over-the-counter medications are excluded under Medicare Part D and will continue to be Title XIX reimbursable for Title XIX eligible persons. The T/RBHAs will use state funds to pay for these excluded drugs for behavioral health recipients

determined to have a SMI. The use of state funds for excluded Medicare Part D drugs for non-Title XIX, non-SMI recipients are based on available funding as determined by the T/RBHA.

The Department considers a "non-covered drug" to be any drug that is not available through the Part D plan's formulary. Drugs that can be obtained through the Part D plan via step therapy or prior authorization processes are not considered "non-covered drugs". State funds will be used for payment of non-covered drugs for dual eligibles and behavioral health recipients determined to have a SMI. The use of state funds for non-covered Medicare Part D drugs for non-Title XIX, non-SMI recipients are based on available funding as determined by the T/RBHA.

Billing for payment of excluded and non-covered Medicare Part D drugs must be done on the Universal Pharmacy Claim Form.

D. Provision of Services

1. Eligibility and Funding Source

Factors that may impact the provision and availability of behavioral health services are the eligibility status of the person being served as well as the funding source and fund availability. ADHS/DBHS is responsible for providing services to persons with behavioral health needs including:

- Title XIX eligible persons enrolled with Arizona Health Care Cost Containment System (AHCCCS) acute care health plans or Indian Health Services (IHS).
- Title XIX eligible persons enrolled with Arizona Long Term Care System (ALTCS) - Department of Economic Security – Division of Developmental Disability (DES-DDD).
- Title XXI (Kids Care) eligible children and parents enrolled with AHCCCS acute care health plans.
- Non-Title XIX/XXI eligible persons.

Depending on a person's eligibility status, funding can impact benefit coverage. While the covered service array is the same for Title XIX/XXI and non-Title XIX/XXI eligible persons, services for non-Title XIX/XXI persons must be paid for with non-Title XIX/XXI monies. In addition, non-Title XIX/XXI funds are used to pay for services (e.g. flex fund services and room and board), not covered by Title XIX/XXI, to both Title XIX/XXI and non-Title XIX/XXI eligible persons. The ability to provide these services may be limited by the amount of state funds that are appropriated annually or by the availability of other non-Title XIX/XXI funds. Since non-Title XIX/XXI funds are limited, ADHS/DBHS requires they be prioritized according to procedures set forth in ADHS/DBHS policy.

Lastly, some coverage restrictions may apply depending on the funding source. For example, the Federal Substance Abuse Prevention and Treatment Performance Partnership Block Grant designates both the type of service to be funded as well as the priority populations to be served.

2. Enrollment

All persons who receive behavioral health services whether on short term (one or two services) or long term basis must be enrolled in the ADHS/DBHS system.

Those instances when services can be provided to non-enrolled individuals include:

- Emergency/crisis intervention services provided to a non-registered person. *
- Case management services involving outreach to individuals and families.
- Prevention services provided to groups of individuals and/or in community settings.

- HIV related services that are provided confidentially.

When encounters are submitted for "unidentified" individuals receiving crisis or case management services, the service provider should use the applicable pseudo-ID numbers (e.g., NR010XXMO) that are assigned to each RBHA. See Provider Manual Attachment 6.1.1, Pseudo Identification Numbers. Encounters are not submitted for prevention services.

* Title XIX/XXI individuals must be enrolled effective no later than the date of first contact.

3. Family Members

For purposes of service coverage and this guide, family is defined as:

(1) "The primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family."

In many instances it is important to provide behavioral health services to the family member as well as the person seeking services. For example, family members may need help with parenting skills, education regarding the nature and management of the mental health disorder, or relief from care giving. Many of the services listed in the service array can be provided to family members, regardless of their enrollment or entitlement status as long as the enrolled person's treatment record reflects that the provision of these services is aimed at accomplishing the service plan goals (i.e., they show a direct, positive effect on the individual). This also means that the enrolled person does not have to be present when the services are being provided to family members.

For situations in which a family member is determined to have extensive behavioral health needs, (e.g., substance abusing parent) the family member her/himself should be enrolled in the system. It is recognized that the ability to provide services to non-Title XIX/XXI eligible family members may be limited depending on the availability of funds.

E. Provider Qualifications and Registration

Any person or agency may participate as an ADHS/DBHS provider if the person or agency is qualified to render a covered service and meets the ADHS/DBHS requirements for provider participation. These requirements include:

- Obtaining any necessary license or certification (including CMS certification for tribal providers).
- Meeting provider standards as set forth in this service guide for the covered service, which the provider wishes to deliver.
- Registering with AHCCCS as an AHCCCS provider or in rare instances with ADHS/DBHS as a DBHS-only provider.
- Obtaining an AHCCCS provider ID if AHCCCS registered provider.
- Obtaining an ADHS/DBHS provider ID as directed by ADHS/DBHS.
- Contracting with the appropriate Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (TRBHA).

For some services, individual providers both provide the service as well as are required to register and bill for the service. In other instances, individual providers are required to be affiliated with an agency that in turn is responsible for billing for the service. Individual provider qualification and provider billing requirements are discussed for each service in Section II of this guide.

1. AHCCCS Registered Providers

For most covered behavioral health services, a provider must be registered with the AHCCCS Administration as a Title XIX/XXI provider regardless of whether the service is provided to a Title XIX/XXI or a non-Title XIX/XXI eligible individual. (See discussion below regarding billing provider type).

Category of Service

For most provider types there are mandatory as well as optional AHCCCS Categories of Services (COS). In addition to the provider type, the COS will determine the specific services for which the provider can bill. For purposes of behavioral health, the following COSs are relevant:

01 – Medicine
09 – Pharmacy
10 – Inpatient Hospital
12 – Pathology & Laboratory
13 – Radiology
14 – Emergency Transportation
16 – Outpatient Facility Fees
26 – Respite Care Services
31 – Non-Emergency Transportation
35 – Adult Foster Care Home
39 – Habilitation
47 – Mental Health Services

- In order to qualify for some of these COSs the providers may have to meet additional licensing/certification requirements. It is important for providers when registering to make sure they qualify and register for the necessary COS that will allow them to bill the desired service codes. Providers should reference *Appendix B.2. ADHS/DBHS Allowable Procedure Code Matrix* to identify the applicable COS associated with each procedure code.

Additional information as well as registration materials may be obtained by calling the AHCCCS Provider Registration Unit at (602) 417-7670 (option 5) or 1-800-794-6862.

2. DBHS-Only Registered Providers

In rare instances, providers may register with ADHS/DBHS as a DBHS-only provider. This should occur only when a provider:

- Has a contract with a T/RBHA;
- Is not able to qualify under any of the existing AHCCCS provider types that are allowed to bill for the particular service being provided;
- Meets the qualification of one of the DBHS-only provider types; and
- Will be billing Non-Title XIX/XIX reimbursable codes only (e.g., H0043 Supported Housing)

Currently there are two (2***)*** DBHS-only provider types. These DBHS-only provider types include:

- S2 – Other
- S3 – Tribal Traditional Service Practitioner

Additional information, including registration materials, may be obtained by calling the ADHS/DBHS Office of Program Support at (602) 364-4704 and asking to be directed to the person responsible for overseeing the DBHS-only provider registration process.

3. Tribal Provider Certification and Registration

In addition to registering with AHCCCS and in lieu of OBHL licensure, tribal providers must be certified by the Center for Medicare and Medicaid Services (CMS) to provide services. Tribal providers must submit completed certification forms indicating that the provider meets the same standards as other comparable providers. AHCCCS will review the provider application and submit the CMS certification to CMS for approval.

Additional information regarding tribal provider certification and registration can be found in the *AHCCCS Native American FFS Provider Manual*.

4. Individuals Employed by or Under Contract with Licensed OBHL Agencies

For licensed OBHL residential and outpatient clinics, there are three (3) types of individual providers who are not allowed to bill independently for services. These include:

- Behavioral Health Professionals: Only a subset of behavioral health professionals as defined in A.A.C. R9-20 must be affiliated with an Outpatient Clinic. This primarily includes social workers, counselors, marriage and family therapists, and substance abuse counselors who are licensed by the Arizona Board of Behavioral Health Examiners pursuant to ARS Title 32, Chapter 33 or other recognized licensing boards and who either are not allowed to practice independently or do not meet the AHCCCS registration criteria as an independent biller (Provider Types 08, 11, 18, 19, 31, 85, 86, 87 and A4).

- Behavioral Health Technicians as defined in A.A.C. R9-20.

- Behavioral Health Paraprofessionals as defined in A.A.C. R9-20.

5. Community Service Agencies

Non-OBHL licensed agencies can become a community service agency and provide rehabilitation and support services. To provide these services, individual providers have to meet certain qualifications and have to be associated with a community service agency.

In addition to meeting specific provider requirements set forth in this guide for the services they will be providing, these providers will need to submit certain documentation as part of their registration packet. A description of documentation requirements is described in ADHS/DBHS Policy MI 5.2, *Community Service Agencies-Title XIX Certification* available on line at http://www.azdhs.gov/bhs/policy.htm.

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6. Habilitation Providers

A Habilitation Provider is a home and community based service provider certified through the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) and registered with the AHCCCS Administration. T/RBHAs must ensure adequate liability insurance before contracting with a Habilitation Provider, regardless if the provider is a DES certified individual or agency.

Prior to the delivery of behavioral health services, the Habilitation Provider must receive an orientation to the unique characteristics and specific needs of the eligible person under their care. Habilitation Providers must be informed regarding whom to contact in an emergency, significant events or other incidents involving the eligible person. The clinical liaison or designee is responsible for the timely review and resolution of any known issues or complaints involving the eligible person and a Habilitation Provider.

Effective April 1, 2003, AHCCCS added COS 47 to certain Habilitation Providers (Provider Type 39). Those providers who registered with AHCCCS on or after April 1, 2003 and who are ADES/HCBS certified to provide habilitation services will automatically be given COS 47 in their profile. Only the following COS 47[1] and COS 26 codes will be available to Provider Type 39:

H2014 – Skills training and development
H2014 HQ – Skills training and development, group
S5150 and S5151 – Unskilled respite (COS 26)
T1019 and T1020 – Personal care services
H2017 – Psychosocial rehabilitation service
S5110 – Home care training, family

The child and family team or the eligible person's treatment team as part of the service planning process must periodically review services provided by Habilitation Providers. Further, services provided by Habilitation Providers must be documented per ADHS/DBHS policy.

7. Adult Foster Care Providers

Effective October 1, 2003, AHCCCS added COS 35 to Provider Type A5, Behavioral Health Therapeutic Home. Current Provider Types A5 who wish to bill for Adult HCTC using the code S5109 HB or S5109 HC must contact AHCCCS Provider Registration and request that COS 35 be added to their profile.

[1] This change affects Provider Type 39 providers who become registered with AHCCCS from April 1, 2003 and onward. Provider Type 39 providers who registered with AHCCCS before April 1, 2003 and wish to bill the above codes must contact provider registration and request COS 47 to be added to their existing profile. Only providers who have ADES/HCBS certification to provide habilitation qualify for the COS 47.

F. Billing for Services

In addition to the general principles related to the provision of services, there are also general guidelines, which must be followed in billing for covered behavioral health services to ensure that services will be reimbursed, and/or the encounters accepted.

1. Service Codes

There are two types of codes that can be billed for services provided:

- AHCCCS Allowable Codes that may be paid for with Title XIX/XXI funds and/or non-XIX/XXI funds depending on the person's eligibility status; and
- Codes that are not allowable under AHCCCS and can **only** be paid for with non-Title XIX/XXI funds.

a. AHCCCS Allowable Codes

AHCCCS allowable codes are to be used to bill for services provided to any person eligible to receive services through ADHS/DBHS, regardless of his/her eligibility status (e.g., Title XIX/XXI, non-Title XIX/XXI). To bill AHCCCS allowable codes the provider must be an AHCCCS registered provider.

AHCCCS allowable codes can be further subdivided into the following categories:

(1.) CPT

- Physicians' Current Procedural Terminology (CPT) contains nationally recognized service codes. For more information regarding these codes see the *Physicians' Current Procedural Terminology (CPT) Manual,* which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic or therapeutic procedures.

(2.) HCPCS

Healthcare Procedure Coding System (HCPCS) contains nationally recognized service codes. For more information regarding these codes see the *Healthcare Procedure Coding System (HCPCS) Manual,* which is a systematic listing and coding for reporting the provision of supplies, materials, injections and certain non-physician services and procedures. A subset of the HCPCS codes are not Title XIX/XXI reimbursable; these are identified in *Appendix B.2 ADHS/DBHS Allowable Procedure Code Matrix.*

(3.) National Drug Codes (NDC)

These nationally recognized drug codes are used to bill for prescription drugs. Information regarding these pharmacy-related codes can be found in the *First Data Bank Blue Book.*

(4.) UB92 Revenue Codes

These nationally recognized revenue codes are used to bill for all inpatient and certain residential treatment services. Information regarding these codes can be found in the *UB92 Manual.*

b. Codes that are not Allowable under AHCCCS

Some codes are not reimbursable under Title XIX/XXI. *Appendix B.2. ADHS/DBHS Allowable Procedure Code Matrix* identifies the service codes that are not reimbursable through AHCCCS funding. If there is not an applicable AHCCCS allowable code, then these codes may be used to bill for the service. These codes may be billed regardless of the person's Title XIX/XXI eligibility status. Depending on the code, these services may be billed by both AHCCCS registered providers as well as DBHS-only providers. These codes include: H0043, H0046 SE, H0046, S9986, T1013, 97810, 97811, 97813 and 97814.

2. Billing Provider Types

There are two (2) categories of providers who can bill for services: AHCCCS provider billing types and DBHS-only provider billing types. ***Appendix B.2. Allowable Procedure Code Matrix*** provides a listing by service codes of the provider types that can bill for the service. Additionally, claims may also be submitted for services provided by a registered AHCCCS provider by an organization that registers as a group billing provider as described at the end of this section.

a. AHCCCS Provider Billing Types

All AHCCCS reimbursable service codes must be billed by an AHCCCS registered provider. AHCCCS provider billing types relevant to behavioral health providers include the following:

02 – Level I Hospital
03 – Pharmacy
04 – Laboratory
06 – Emergency Transportation
08 – Physician (Allopathic)*
11 – Psychologist*
12 – Certified Registered Nurse Anesthetist
18 – Physician Assistant*
19 – Nurse Practitioner*
28 – Non-emergency Transportation
31 – Physician (Osteopathic)*
39 – Habilitation Provider
71 – Level I Psychiatric Hospital (IMD)
72 –Tribal Regional Behavioral Health Authority / Regional Behavioral Health Authority (T/RBHA)
73 – Out-of-state, One Time Fee For Service Provider
74 – Level II Behavioral Health Residential (non-IMD)
77 – Outpatient Clinic
78 – Level I Residential Treatment Center – Secure (non-IMD)
85 – Licensed Clinical Social Worker*
86 – Licensed Marriage / Family Therapist*
87 – Licensed Professional Counselor*
97 – Air Transport Providers
A2 – Level III Behavioral Health Residential (non-IMD)
A3 – Community Service Agency
A4 – Licensed Independent Substance Abuse Counselor
A5 – Behavioral Health Therapeutic Home
A6 – Rural Substance Abuse Transitional Center
B1 – Level I Residential Treatment Center – Secure (IMD)
B2 – Level I Residential Treatment Center – Non-Secure (non-IMD)
B3 – Level I Residential Treatment Center – Non-Secure (IMD)
B5 – Level I Subacute Facility (non-IMD)
B6 – Level I Subacute Facility (IMD)
B7 – Level I Crisis Services

* These individuals are referred to as "Independent Billers".

In addition to having the correct provider type, providers also have to be registered to provide the COS in which the service code is classified.

b. DBHS-Only Provider Billing Types

DBHS-only provider types can only bill using Non-Title XIX/XXI reimbursable codes and include the following:

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- S2 - Other
- S3 – Tribal Traditional Service Practitioner

3. Modifiers

In some instances, in order to clearly delineate the service being provided, a "modifier" must be submitted along with the service code. In these circumstances codes are assigned modifiers as described in the text of this guide and in *Appendix B.2. ADHS/DBHS Allowable Procedure Code Matrix.* Modifiers are required to distinguish the use of certain procedures. For example, there is a single code for counseling, but reimbursement for counseling provided in the office, the home or in group can vary, so the accurate use of modifiers is essential. Assigned codes and, when applicable modifiers, must be used on submitted claims and encounters to specify service(s) rendered. The following is a list of modifiers used in this guide:

GT- Telecommunication[2]
HA- Child/Adolescent Program
HB- Adult Program, Non Geriatric
HC- Adult Program, Geriatric
HG- Opioid addiction treatment program
HN- Bachelors degree program (for staff not designated as behavioral health professionals)
HO- Masters degree level (for behavioral health professionals)
HQ- Group setting
HR- Family/couple with client present
HS- Family/couple without client present
HT- Multi-disciplinary team
HW- Funded by State Mental Health Agency
SE- State and/or federally funded programs/services
TF- Intermediate level of care
TG- Complex/high level of care
TN- Rural

4. Place of Service (POS) Codes

Accurate POS codes must be submitted on claims and encounters to specify where service(s) were rendered. The following is a list of place of service codes used in this guide:

04- Homeless Shelter
11- Office
12- Home

[2] The physical location of the provider, when providing services via telecommunication, is the location used as the billable place of service.

15- Mobile Unit
20- Urgent Care Facility
21- Inpatient Hospital
22- Outpatient Hospital
23- Emergency Room-Hospital
31- Skilled Nursing Facility
32- Nursing Facility
33- Custodial Care Facility
41- Ambulance-Land
42- Ambulance-Air or Water
50- Federally Qualified Health Center
51- Inpatient Psychiatric Facility
52- Psychiatric Facility Partial Hospitalization
53- Community Mental Health Center
55- Residential Substance Abuse Treatment Facility
56- Psychiatric Residential Treatment Center
71- State or Local Public Health Clinic
72- Rural Health Clinic
81- Independent Laboratory
99- Other

5. Group Billing

Any organization may act as the financial representative for any AHCCCS registered provider or group of providers who have authorized this arrangement. Such an organization must register with AHCCCS as a group billing provider. Under their group biller number, the organization may not provide services or bill as the service provider. Group Billers submit claims and encounters to the RBHA according to established procedures. The RBHA then submits the claims and encounters to ADHS/DBHS. TRBHA subcontracted providers submit claims directly to AHCCCS according to established procedures.

Each AHCCCS registered provider using the group billing arrangement must sign a group billing authorization form and must make sure that their provider ID number appears on each claim even though a group billing number may be used for payment. If a provider has multiple locations, the provider may be affiliated with multiple group billing associations.

6. Diagnosis Codes

Covered behavioral health services may be provided to persons regardless of their diagnosis or even in the absence of any diagnosis at the time of services, so long as there are documented behaviors or symptoms that require treatment. This means that a diagnosis is not necessary prior to enrolling a person in the ADHS/DBHS system. Likewise, the provision of covered services is not limited by a person's diagnosis (e.g., any of the covered services may be provided to address both mental

illness and substance abuse disorders, at-risk behaviors / conditions or family members impacted by the person's disorder). While a diagnosis is not needed to receive treatment, a diagnostic code is needed for service code billing.

The ICD-9-CM diagnosis codes must be used when submitting claims and encounters (see the *International Classification of Diseases – 9th Revision – Clinical Modification Manual)*. While each claim or encounter must include at least one valid ICD-9 diagnosis code describing the person's condition, there are a number of very general ICD-9 codes that can be used for those cases in which no specific diagnosis has been established at the time of the service.

If a code of 799.9 is assigned under the DSM-IV criteria and is not changed to a more specific diagnostic or descriptive "V" code before a claim is submitted to ADHS/DBHS, the AHCCCS PMMIS data system reads it as if it were an ICD-9-CM code, that is, the clinician does not know what the specific problem is. This diagnosis code will be denied for any inpatient or laboratory service. Further, it is difficult to gather meaningful data regarding populations, trends and program effectiveness when the primary diagnostic code is 799.9.

Providers are strongly encouraged to limit the use of 799.9 and to use instead codes, which more clearly describe the person's situation. An individual who presents to the mental health system for services but who does not have a diagnosis on Axis I or II will very likely have a situation that is described by a "V" code (e.g., V61.20, counseling for parent-child problem, unspecified; V61.21, counseling for victim of child abuse, etc.).

Encounters/claims for revenue codes submitted by inpatient providers (02, 71, 78, B1, B2, B3, B5, B6) must be submitted indicating a primary ICD-9 diagnosis in the range of 290.00 to 316.99. Although a patient may have other diagnosis codes (e.g., a "V" code or other ICD-9 diagnostic code outside this range), the inpatient encounter/claim for inpatient psychiatric service must indicate a valid mental health or substance abuse diagnosis in the above range as primary to adjudicate successfully.

Although ICD-9 and DSM-IV diagnosis codes are substantially alike, DSM-IV codes must not be used (see 2007 ICD-9-CM manual). Areas of differences include:

- Three ICD-9 codes (i.e., 312.8, 995.5 and v6.1) require that a 5th digit be used in order to be correct. See manual to determine appropriate 5th digit to be used.

ICD-9 codes should be used at their highest level of specificity (i.e., highest number of digits possible). This means:

- Use a three-digit code only if there is no four-digit code within the coding category.
- Use a four-digit code only if there is no fifth digit subclassification for that category.
- Use a five-digit code for those categories where the fifth digit subclassification exists.

ICD-9 codes are the industry standard and are required for Medicaid/Medicare billing purposes.

7. Core Billing Limitations

For some of the services there are core billing limitations, which must be followed when billing for services. Services may have additional billing limitations, which are applicable to that specific service. These specific billing limitations are set forth in Section II of this guide.

a. General Core Billing Limitations

General core billing limitations include the following:

1. A provider can only bill for his/her time spent in providing the actual service. For all services, the provider may not bill any time associated with note taking and/or medical record upkeep as this time has been included in the rate.

2. For all services except case management and assessment services, the provider may not bill any time associated with phone calls, leaving voice messages, sending emails and/or collateral contact with the enrolled person, family and/or other involved parties as this time is included in the rate calculation.

3. The provider may only bill the time spent in face-to-face direct contact; however, when providing assessment, case management services, the provider may also bill indirect contact. Indirect contact includes phone calls, leaving voice messages and sending emails (with limitations), picking up and delivering medications, and/or collateral contact with the enrolled person, family and/or other involved parties.

4. A provider should bill all time spent in directly providing the actual service, regardless of the assumptions made in the rate model.

5. A professional who supervises the Behavioral Health Professional, Behavioral Health Technician and/or Behavioral Health Paraprofessional providing the service may not bill this supervision function as a HCPCS/CPT code. Employee supervision has been built into the service code rates. Supervision means direction or oversight of behavioral health services provided by a

qualified individual in order to enhance therapeutic competence and clinical insight and to ensure client welfare by guiding, evaluating, and advising how services are provided.

6. If the person and/or family member(s) misses his/her appointment, the provider may not bill for the service.

7. Parents (including natural parent, adoptive parent and stepparent) **may** only provide personal care services if the adult child receiving services is 21 years or older and the parent is not the adult child's legal guardian. Under **no** circumstances may the spouse be the personal care services provider. The T/RBHA is responsible for monitoring that personal care services are provided by appropriate personnel.

8. Parents (including natural parent, adoptive parent and stepparent) who are certified Habilitation providers may only encounter/bill for applicable covered behavioral health services delivered to their adult children who are 21 years or older.

9. When necessary, covered services, in addition to those offered through an OBHL Level I, Level II or Level III facility, may be delivered to the enrolled person. See the billing limitation section associated with each specific service for additional information.

10. For services with billing units of 15 minutes, the first unit of service can be encountered/billed when 1 or more minutes are spent providing the service. To encounter/bill subsequent units of the service, the provider must spend at least one half of the billing unit for the subsequent units to be encountered/billed. If less than one half of the billing unit is spent providing the service, then only the initial unit of service can be encountered/billed.

11. More than one provider agency may bill for certain services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs. Please refer to the billing limitations for each service for applicability.

12. If otherwise allowed, service codes may be billed on the same day as admission to and discharge from inpatient services (e.g., billing Crisis Intervention Service (H2011) on the same day of admission to Inpatient Hospital (0114)).

b. Core Provider Travel Billing Limitations

The mileage cost of the first 25 miles of provider travel is included in the rate calculated for each service; therefore, provider travel mileage may not be billed separately except when it exceeds 25 miles. In these circumstances, providers bill

the additional miles traveled in excess of 25 miles using the provider code of A0160.

When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel. The following examples demonstrate when to bill for additional miles:

- If Provider A travels a total of 15 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), travel time and mileage is included in the rate and may not be billed separately.

- If Provider B travels a total of 40 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), the first 25 miles of provider travel are included in the rate but the provider may bill 15 miles using the provider code A0160 (40 miles minus 25 miles).

- If Provider C travels to multiple out-of-office settings (in succession), he/she must calculate provider travel mileage by segment. For example:
  First segment = 15 miles; 0 travel miles are billed
  Second segment = 35 miles; 10 travel miles are billed
  Third segment = 30 miles; 5 travel miles are billed
  Total travel miles billed = 15 miles are billed using provider code A0160.
  The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.

- If a behavioral health professional, behavioral health technician or behavioral health paraprofessional travels to provide case management services or provider type 85, 86, 87 or A4 travels to provide services to a client and the client misses the appointment, the intended service may not be billed. However, the provider may bill for the full mileage traveled (even if the mileage is less than 25 miles) for the missed appointment. The provider should use service code A0160 for billing and report actual miles traveled.

8. Telemedicine

While telemedicine is not a treatment service ("modality") ADHS/DBHS does recognize real time telemedicine as an effective mechanism for the delivery of certain covered behavioral health services (see *ADHS/DBHS Policy CO 1.3 Use of Telemedicine*). The following types of covered behavioral health services may be delivered to persons enrolled with a T/RBHA utilizing telemedicine technology:

- Diagnostic consultation and assessment
- Psychotropic medication adjustment and monitoring
- Individual and family counseling

- Case management

A complete listing of the services that can be billed utilizing telemedicine can be found in ***Appendix B.2. –Allowable Procedure Code Matrix***. Services provided through telemedicine should be billed/encountered as any other specialty consultation with the exception that the 'GT' modifier must be used to designate the service being billed as telemedicine.

9. Claim Information

For more detailed information about how to complete claim forms refer to the *AHCCCS Fee-For- Service Claims Manual* which can be found on the AHCCCS website: http://www.ahcccs.state.az.us

10. Reimbursement

Appendix B.2. –Allowable Procedure Code Matrix provides a listing of fee-for-service rates for each allowable procedure code. These rates function as "default" payment rates for service providers in absence of a contract (i.e., fee-for-service) and for providers subcontracted with a Tribal RBHA. Use of these rates in contracts is not required except for Tribal RBHA subcontracted providers; the Non-Tribal RBHAs are encouraged to use them only as benchmarks when contracting for services.

II. Service Descriptions

II. A. Treatment Services

Treatment services are provided by or under the supervision of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services have been further grouped into the following three subcategories:

- Behavioral Health Counseling and Therapy
- Assessment, Evaluation and Screening Services
- Other Professional

II. A. 1. Behavioral Health Counseling and Therapy

General Information

General Definition

An interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral problems or conflicts, and provide support, education or understanding for the person, group or family to resolve or manage the current problem

or conflict and prevent, resolve or manage similar future problems or conflicts. Services may be provided to an individual, a group of persons, a family or multiple families.

Service Standards/Provider Qualifications

Behavioral Health Counseling and Therapy services must be provided by individuals who are qualified *behavioral health professionals* or *behavioral health technicians* as defined in A.A.C. Title 9, Chapter 20.

For behavioral health counseling and therapy services that are billed by a behavioral health agency, the agency must be licensed by OBHL and meet the requirements for the provision of behavioral health counseling and therapy services as set forth in A.A.C. Title 9, Chapter 20.

Code Specific Information

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION-Individual Counseling and Therapy
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient

90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90845	Medical psychoanalysis - No units specified.
90880	Hypnotherapy

CODE	**DESCRIPTION-Family Counseling and Therapy**
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy, with patient present)
90849	Multiple-family group psychotherapy

CODE	**DESCRIPTION-Group Counseling and Therapy**
90853	Group psychotherapy (other than of a multiple-family group)
90857	Interactive group psychotherapy

HCPCS Codes

Except for behavioral health counseling and therapy services provided by those individual behavioral health professionals allowed to bill CPT codes, all other behavioral health counseling and therapy services should be billed using the following HCPCS codes.

- **H0004 - Individual Behavioral Health Counseling and Therapy--Office:** Counseling services (see general definition above for behavioral health counseling and therapy) provided face-to-face at the provider's work site to an individual person.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Urgent Care Facility (20)
  Outpatient Hospital (22)
  Federally Qualified Health Center (50)
  Community Mental Health Center (53)
  Rural Health Clinic (72)

  Billing Unit: 15 minutes

- **H0004 - Individual Behavioral Health Counseling and Therapy – Home:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to an individual person at the person's residence or other out-of-office setting.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Home (12)
  Skilled Nursing Facility (31)

Nursing Facility (32)
Custodial Care Facility (33)
Other (99)

Billing Unit: 15 minutes

- **H0004 HR - Family Behavioral Health Counseling and Therapy– Office, With Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to the member and member's family at the provider's work site. ****HR modifier required and must specify place of service****

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Urgent Care Facility (20)
  Outpatient Hospital (22)
  Federally Qualified Health Center (50)
  Community Mental Health Center (53)
  Rural Health Clinic (72)

  Billing Unit: 15 minutes per family

- **H0004 HS - Family Behavioral Health Counseling and Therapy– Office, Without Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a person's family at the provider's work site. ****HS modifier required and must specify place of service****

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Homeless Shelter (04)
  Office (11)

Urgent Care Facility (20)
Outpatient Hospital (22)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
Rural Health Clinic (72)

Billing Unit: 15 minutes per family

- **H0004 HR – Family Behavioral Health Counseling and Therapy – Out-of-Office, With Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a person's family at the family's residence or other out-of-office setting. ****HR modifier required and must specify place of service****

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Home (12)
  Other (99)

  Billing Unit: 15 minutes per family

- **H0004 HS – Family Behavioral Health Counseling and Therapy—Out-of-Office, Without Client Present:** Counseling services (see general definitions above for counseling) provided face-to-face to members of a person's family at the family's residence or other out-of-office setting. ****HS modifier required and must specify place of service****

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Home (12)
  Other (99)

Billing Unit: 15 minutes per family

- **H0004 HQ[3] - Group Behavioral Health Counseling and Therapy:** Counseling services (see general definition above for counseling and therapy) provided to a group (of any size) of persons, which occurs at a provider's worksite. For example, if eight persons participated in group counseling for 60 minutes, the provider would bill four units for each person for a total of 32 units. ****HQ modifier required and must specify place of service****

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Office (11)
  Outpatient Hospital (22)
  Skilled Nursing Facility (31)
  Nursing Facility (32)
  Custodial Care Facility (33)
  Federally Qualified Health Center (50)
  Community Mental Health Center (53)
  Rural Health Clinic (72)
  Other (99)

Note: Use POS 99 for out-of-office settings not specified above (e.g., at a church).

Billing Unit: 15 minutes per each person in the group

Billing Limitations

For behavioral health counseling and therapy services the following billing limitations apply:

[3] Generally, H0004 HQ (Group Behavioral Health Counseling and Therapy) may not be billed on the same day as Level I Residential Treatment Center (0114, 0124, 0134, 0154, 0116, 0126, 0136 or 0156) or Behavioral Health Short-Term Residential (H0018, H0019) Services. However, based on behavioral health recipient needs, certain specialized group behavioral health counseling and therapy services may be billed on the same day as Level I Residential Treatment Center or Behavioral Health Short-Term Residential Services. The clinical rationale for providing specialized group behavioral health counseling and therapy services must be specifically documented in the Service Plan and Progress Note. ADHS/DBHS has created a quarterly report to monitor the appropriate use of H0004 HQ when billed on the same day as Level I Residential Treatment Center or Behavioral Health Short-Term Residential services.

1. See general core billing limitations in Section I.

2. Provider travel time is included in the rates for H0004—Individual Behavioral Health Counseling and Therapy, Family Behavioral Health Counseling and Therapy, and Group Behavioral Health Counseling and Therapy. See core provider travel billing limitations in Section I.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. More than one provider agency may bill for behavioral health counseling and therapy services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

II. A. 2. Assessment, Evaluation and Screening Services

General Information

General Definition

Gathering and assessment of historical and current information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report and recommendations.

Service Standards/Provider Qualifications:

Behavioral health professionals or *behavioral health technicians* (as defined in A.A.C. Title 9, Chapter 20) must meet the ADHS/DBHS credentialing and privileging requirements in order to provide assessment and evaluation services.

For behavioral health screening, assessment and evaluation services that are billed by a behavioral health agency, the agency must be licensed by OBHL and meet the requirements for the provision of behavioral health assessment, evaluation and screening services as set forth in A.A.C. Title 9, Chapter 20.

Code Specific Information

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer TO ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION- Assessment, Evaluation and Screening Services
90801	Psychiatric diagnostic interview examination. Unit unspecified.
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or

	physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach, WAIS), administered by a computer, with qualified health care professional interpretation and report.
96110	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report.
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning
96116	Neurobehavioral behavioral status exam (clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
99241	Office consultation for a new or established patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and medical decision-making for a minor

	presenting problem. (Approx. 15 minutes)
99242	Office consultation for a new or established patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and, straightforward medical decision-making for problems of a low severity. (Approx 30 minutes)
99243	Office consultation for a new or established patient, which requires 3 key components: a detailed history; a detailed examination; and, medical decision-making for a problem of low complexity. (Approx. 40 minutes)
99244	Office consultation for a new or established patient, which requires 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity for problems of a moderate/high severity. (Approx. 60 minutes)
99245	Office consultation for a new or established patient, which requires 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making for a problem of high severity. (Approx. 80 minutes)
99304	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem and the patient's and/or family's needs. Usually the problem(s) requiring admission are of low severity.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually, the problem(s) requiring admission are of moderate severity.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Usually, the problem(s) requiring admission are of high severity.

99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Usually, the patient is stable, recovering or improving.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Usually, the patient has developed a significant complication or a significant new problem.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.
99315	Nursing facility discharge day management. (30 minutes or less)
99316	Nursing facility discharge day management. (More than 30 minutes)
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity. Usually, the patient is stable, recovering, or improving. (Do not report 99318 on the same day of service as nursing facility services codes 99304-99316)

HCPCS Codes

Except for assessment, evaluation and screening provided by those independently registered individual behavioral health professionals billing CPT codes, all other

assessment, evaluation and screening services should be billed using the following HCPCS codes.

- **H0001 – Alcohol and/or drug assessment**

  Provider Qualifications:
  ADHS/DBHS credentialed and privileged behavioral health professionals and behavioral health technicians

  Billing Provider Type
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Other (99)

  Billing Unit: 1

- **H0002 - Behavioral Health Screening to Determine Eligibility for Admission:** Information gathered using a standardized screening tool or criteria including those behavioral health screening activities associated with DUI screening. Includes the triage function of making preliminary recommendations for treatment interventions or determination that no behavioral health need exists and/or assisting in the development of the person's service plan. May also include the preliminary collection of information necessary to complete a supported employment assessment.

  Provider Qualifications:
  Behavioral health technician or behavioral health professional as defined in A.A.C. Title 9, Chapter 20.

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)
  Rural Substance Abuse Transitional Agency (A6)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Home (12)
  Urgent Care Facility (20)
  Inpatient Hospital (21)
  Outpatient Hospital (22)

Emergency Room – Hospital (23)
Federally Qualified Health Center (50)
Inpatient Psychiatric Facility (51)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H0031- Mental Health Assessment –By Non-Physician-** Gathering and assessment of information necessary for assessment of a person, resulting in a written summary report. Recommendations, which may be in response to specific questions posed in an assessment request, are made to the person, family, referral source, provider, or courts, as applicable. May also include the review and modifications to the person's service plan, comprehensive assessments, a rehabilitative employment support assessment and DES-DDD Positive Support Plans.

  Provider Qualifications:
  ADHS/DBHS credentialed and privileged behavioral health professionals and behavioral health technicians

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Rural Substance Abuse Transitional Agency (A6)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Home (12)
  Urgent Care Facility (20)
  Inpatient Hospital (21)
  Outpatient Hospital (22)
  Emergency Room – Hospital (23)
  Federally Qualified Health Center (50)
  Inpatient Psychiatric Facility (51)
  Community Mental Health Center (53)
  State or Local Public Health Clinic (71)
  Rural Health Clinic (72)
  Other (99)

Billing Unit: 30 minutes

Billing Limitations

For assessment, evaluation and screening services the following billing limitations apply:

1. See general core billing limitations in Section I.
2. Where applicable travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation (emergency and non-emergency) provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Rehabilitative employment support assessments may only be provided when the assessment service is not available through the federally funded Rehabilitation Act program administered by Department of Economic Security – Rehabilitation Service Administration (DES-RSA) or the Tribal Rehabilitation Services Administration. The T/RBHA must monitor the proper provision of this service.

5. Preparation of a report of a member's psychiatric status for primary use with the court is not Title XIX/XXI reimbursable. Title XIX/XXI funds may be used for a report to be used by a treatment team or physician. The fact that the report may also be used in court does not disqualify the service for Title XIX/XXI reimbursement.

II. A. 3. Other Professional

General Information

In addition to behavioral health counseling therapy and assessment, evaluation and screening, there are a number of other treatment services that may be provided by qualified individuals in order to reduce symptoms and improve or maintain functioning. These services are described below.

Code Specific Information

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION-Other Professional
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes
90899	Unlisted psychiatric services or procedure
90901	Biofeedback training by any modality
99199	Unlisted special service or report

State Funded HCPCS Codes (not reimbursable by Medicaid Title XIX or KidsCare Title XXI)

- **H0046 –Mental Health Services (NOS) (formerly Traditional Healing Services):** Treatment services for mental health or substance abuse problems provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability.

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)

Outpatient Clinic (77)
Community Service Agency (A3)
Tribal Traditional Service Practitioner (S3)

Place of Service:
Office (11)
Home (12)
Inpatient Hospital (21)
Outpatient Hospital (22)
Federally Qualified Health Center (50)
Inpatient Psychiatric Facility (51)
Community Mental Health Center (53)
Residential Substance Abuse Treatment Facility (55)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

Auricular Acupuncture general definition:
The application by a certified acupuncturist practitioner pursuant to A.R.S. 32-3921 of auricular acupuncture needles to the pinna, lobe or auditory meatus to treat alcoholism, substance abuse or chemical dependency.

- **97810 –Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.**
  - **+97811 –each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s).**

- **97813-Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.**
  - **+97814-each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s).**

Billing Provider Type:
Hospital (02)
Psychiatric Hospital (71)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Level III Behavioral Health Residential (A2)
Level I Residential Treatment Center – Secure (IMD) (B1)
Level I Residential Treatment Center – Non Secure (non IMD) (B2)
Level I Residential Treatment Center – Non Secure (IMD) (B3)
Level I Subacute (non-IMD) (B5)
Level I Subacute (IMD) (B6)

Place of Service:
Office (11)
Inpatient Hospital (21)
Outpatient Hospital (22)
Inpatient Psychiatric Facility (51)
Community Mental Health Center (53)
Residential Substance Abuse Treatment Facility (55)
Psychiatric Residential Treatment Center (56)
Other (99)

Billing Unit: Not applicable

II. B. Rehabilitation Services

Rehabilitation services include the provision of education, coaching, training, demonstration and other services including securing and maintaining employment to remediate residual or prevent anticipated functional deficits. Except for cognitive rehabilitation, which is billed using a CPT code, rehabilitation services are billed using HCPCS codes. Rehabilitation services include:

- Skills Training and Development and Psychosocial Rehabilitation Living Skills Training
- Cognitive Rehabilitation
- Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion)
- Psychoeducational Service (Pre-Job Training and Job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)

II. B. 1. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training

General Information

General Definition

Teaching independent living, social, and communication skills to persons and/or their families in order to maximize the person's ability to live and participate in the community and to function independently. Examples of areas that may be addressed include self-care, household management, social decorum, same- and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources. Services may be provided to a person, a group of persons or their families with the person(s) present.

Service Standards/Provider Qualifications

Skills training and development and psychosocial rehabilitation living skills training services must be provided by individuals who are qualified *behavioral health professionals*, *behavioral health technicians* or *behavioral health para-professionals* as defined in A.A.C. R9-20. This may also include LPNs who have training in providing these services as required by the person's service plan.

Code Specific Information

HCPCS Codes

Skills training and development and psychosocial rehabilitation living skills training services should be billed using the following codes:

- **H2014 –Skills Training and Development – Individual:** See general definition above.

  Billing Provider Type:
  Habilitation Provider (39)
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Community Service Agency (A3)
  Rural Substance Abuse Transitional Agency (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H2014 HQ –Skills Training and Development – Group:** See general definition above. If eight persons participated in group skills training and development session for 60 minutes, the provider would bill four units for each person for a total of 32 units.

  Billing Provider Type:
  Habilitation Provider (39)
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Community Service Agency (A3)
  Rural Substance Abuse Transitional Agency (A6)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Home (12)
  Urgent Care Facility (20)
  Federally Qualified Health Center (50)
  Community Mental Health Center (53)
  State or Local Public Health Clinic (71)
  Rural Health Clinic (72)
  Other (99)

  Billing Unit: 15 minutes per person

- **H2017–Psychosocial Rehabilitation Living Skills Training:** See general definition above.

Billing Provider Type:
Habilitation Provider (39)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Licensed Clinical Social Worker (85)
Licensed Marriage/Family Therapist (86)
Licensed Professional Counselor (87)
Community Service Agency (A3)
Rural Substance Abuse Transitional Agency (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes per person

Billing Limitations

For skills training and development services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Service code H2014, Skills Training and Development, may be billed up to 8 hours. Service code H2017, Psychosocial Rehabilitation, may be billed if more than 8 hours are needed and should be billed for the length of the service. Service codes H2014, Skills Training and Development and Service code H2017, Psychosocial Rehabilitation cannot be billed on the same day.

5. More than one provider agency may bill for skills training and development services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

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II. B. 2. Cognitive Rehabilitation

General Information

General Definition

The facilitation of recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible. Goals of cognitive rehabilitation include: relearning of targeted mental abilities, strengthening of intact functions, relearning of social interaction skills, substitution of new skills to replace lost functioning, controlling the emotional aspects of one's functioning. Treatment may include techniques such as, auditory and visual attention directed tasks, memory training, training in the use of assistive technology, and anger management. Training can be done through exercises or stimulation, cognitive neuropsychology, cognitive psychology and behavioral psychology, or a holistic approach to include social and emotional aspects. Training is generally provided one-on-one and is highly customized to each individual's strengths, skills, and needs.

Service Standards/Provider Qualifications
Cognitive rehabilitation services must be provided by individuals who are qualified *behavioral health professionals* as defined in A.A.C. R9-20 and who can bill independently using the appropriate CPT codes.

Code Specific Information

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION-Cognitive Rehabilitation
97532	Development of cognitive skills to improve attention, memory, problem solving, includes compensatory training, direct (one on one) patient contact by the provider, each 15 minutes.

II. B. 3. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)

General Information

General Definition
Education and training are single or multiple sessions provided to an individual or a group of persons and/or their families related to the enrolled person's treatment plan. Education and training sessions are usually presented using a standardized curriculum with the purpose of increasing an individual's behavioral knowledge of a health-related topic such as the nature of an illness, relapse and symptom management, medication management, stress management, safe sex practices, HIV education, parenting skills education and healthy lifestyles (e.g., diet, exercise). If DUI health promotion education and training is provided it must be provided by an agency with a distinct OBHL DUI license.

Service Standards/Provider Qualifications

Behavioral health prevention/promotion education services may be provided by individuals who are qualified *behavioral health professionals* or *behavioral health technicians* as defined in A.A.C. R9-20 or who are educators or subject matter experts. This may also include other medical personnel, such as LPNs or RNs who are not allowed to bill independently using CPT codes. All individual providers must be appropriately licensed/certified/trained in the area in which they are providing training.

Code Specific Information

HCPCS Codes

Behavioral health prevention/promotion education and medication training and support services should be billed using the following codes:

- **H0025 - Behavioral Health Prevention/Promotion Education:** Services to a target population to affect knowledge, attitude and/or behavior. See general definition above.

  Billing Provider Type:
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Community Service Agency (A3)
  Licensed Independent Substance Abuse Counselor (A4)
  Rural Substance Abuse Transitional Agency (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 30 minutes

- **H0034 – Medication Training and Support:** Education and training provided to a person and/or their family related to the enrolled persons medication regime.

  Billing Provider Type:
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)
  Rural Substance Abuse Transitional Agency (A6)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Home (12)
  Urgent Care Facility (20)
  Federally Qualified Health Center (50)
  Community Mental Health Center (53)
  State or Local Public Health Clinic (71)
  Rural Health Clinic (72)
  Other (99)

  Billing Unit: 15 minutes

Billing Limitations

For behavioral health prevention/promotion education and medication training and support services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. More than one provider agency may bill for behavioral health prevention/promotion education and medication training and support services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

II. B. 4. Psychoeducational Services and Ongoing Support to Maintain Employment

General Information

General Definition

Psychoeducational services and ongoing support to maintain employment services are designed to assist a person or group to choose, acquire, and maintain a job or other meaningful community activity (e.g., volunteer work)

Service Standards/Provider Qualifications

Psychoeducational services and ongoing support to maintain employment services may be provided individually. These services must be provided using tools, techniques and materials which meet the individual needs of the person and which are appropriate for the person's age and mental and physical status. While the optimum goal may be for persons to achieve full time employment in a competitive, integrated work environment, there may be many persons for whom this goal is not appropriate. Therefore, these services need to be tailored to support persons in a variety of settings (e.g., part time job, unpaid work experience or in meaningful volunteer work). Some individuals might not be ready to identify an educational or employment goal, and will need assistance in exploring their strengths as they relate to a variety of goals, eventually identifying an appropriate goal. Some individuals may desire to focus on socialization goals, which should also be addressed in rehabilitation services, and are often the first step to moving towards competitive employment and further independent involvement in the community.

Code Specific Information

HCPCS Codes

- **H2027 – Psychoeducational Services (Pre-Job Training and Development):** Services which prepare a person to engage in meaningful work-related activities may

include: career/educational counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, work activities, professional decorum and dress, time management, and assistance in finding employment.

Provider Qualifications:

Behavioral health technicians and behavioral health paraprofessionals with one year of experience in providing rehabilitation services to persons with disabilities.

For Community Service Agencies, please see ***ADHS/DBHS Policy MI 5.2 Community Service Agencies—Title XIX Certification*** for further detail on service standards and provider qualifications for this service.

Billing Provider Type:
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Licensed Clinical Social Worker (85)
Licensed Marriage/Family Therapist (86)
Licensed Professional Counselor (87)
Licensed Independent Substance Abuse Counselor (A4)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H2025 – Ongoing Support to Maintain Employment:** Includes support services that enable a person to complete job training or maintain employment. May include monitoring and supervision, assistance in performing job tasks, work-adjustment training, and supportive counseling.

  Provider Qualifications:

Behavioral health technicians and behavioral health paraprofessionals with one year of experience in providing rehabilitation services to persons with disabilities.

For Community Service Agencies, please see ***ADHS/DBHS Policy MI 5.2 Community Service Agencies—Title XIX Certification*** for further detail on service standards and provider qualifications for this service.

Billing Provider Type:
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Licensed Clinical Social Worker (85)
Licensed Marriage/Family Therapist (86)
Licensed Professional Counselor (87)
Licensed Independent Substance Abuse Counselor (A4)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H2026 – Ongoing Support to Maintain Employment (Per diem):** See definition above.

Provider Qualifications:

Behavioral health technicians and behavioral health paraprofessionals with one year of experience in providing rehabilitation services to persons with disabilities.

For Community Service Agencies, please see ***ADHS/DBHS Policy MI 5.2 Community Service Agencies—Title XIX Certification*** for further detail on service standards and provider qualifications for this service.

Billing Provider Type:
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)

Outpatient Clinic (77)
Licensed Clinical Social Worker (85)
Licensed Marriage/Family Therapist (86)
Licensed Professional Counselor (87)
Licensed Independent Substance Abuse Counselor (A4)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: Per Diem

Billing Limitations

For psychoeducational services and ongoing support to maintain employment services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Psychoeducational services and ongoing support to maintain employment services are provided only if the services are not available through the federally funded Rehabilitation Act program administered by DES-RSA, which is required to be the primary payer for Title XIX eligible persons. The T/RBHA must monitor the proper provision of this service.

5. More than one provider agency may bill for psychoeducational services and ongoing support to maintain employment services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

II. C. Medical Services

Medical services are provided by or ordered by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a person's symptoms and improve or maintain functioning. These services have been further grouped into the following four subcategories:

- Medication
- Laboratory, Radiology and Medical Imaging
- Medical Management (including medication management)
- Electro-Convulsive Therapy

II. C. 1. Medication Services

General Information

General Definition

Drugs prescribed by a licensed physician, nurse practitioner or physician assistant to prevent, stabilize or ameliorate symptoms arising from a behavioral health condition or its treatment.

Service Standards/Provider Qualifications

Most prescribed medications must be provided by a licensed pharmacy or dispensed under the direction of a licensed pharmacist. Some medications are administered by (e.g., injections, opioid agonist drugs) or under the direction of a licensed physician, nurse practitioner, or physician assistant.

ADHS/DBHS maintains a minimum list of medications to ensure the availability of necessary, safe and cost effective medications for persons with behavioral health disorders. These medications must be made available to persons in accordance with the ADHS/DBHS Provider Manual Section 3.16, *Medication Formulary*.

Code Specific Information

National Drug Codes

The National Drug Codes (NDC) must be used for billing all prescribed medications dispensed by a pharmacy (provider type 3). These pharmacy claims are reimbursed based on a fee schedule amount plus a dispensing fee.

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	**DESCRIPTION-Medication Services**
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

HCPCS Codes

CODE	**DESCRIPTION-Medication Services**
J0515	Injection, Benztropine Mesylate, 1mg

J1200	Injection, Diphenhydramine HCL, up to 50 mg
J1630	Injection, Haloperidol, up to 5 mg
J1631	Injection, Haloperidol Decanoate, per 50 mg
J2680	Injection, Fluphenazine Decanoate, up to 25 mg
J3410	Injection, Hydroxyine HCL, up to 25 mg
J2794	Injection, Risperidal Consta (Risperidone, long-acting), up to 50 mg

While prescribed opioid agonist drugs that are dispensed by a pharmacy should be billed using the NDC code for the drug itself, the administration of opioid agonist by licensed medical practitioners in an office setting (non-inpatient) should be billed using the codes listed below. The administration of opioid agonist drugs must be done in compliance with federal regulations, (see 21 CFR 291.501 and 505 and 42 CFR Part 8), state regulations (A.A.C. Title 9, Chapter 20, Article 18 and ADHS/DBHS guidelines related to opioid agonist administration.

- **H2010 HG –Comprehensive Medication Services**: Administration of prescribed opioid agonist drugs to a person *in the office setting* in order to reduce physical dependence on heroin and other opiate narcotics. Providers must be AHCCCS registered as a Category of Services (COS) type 01 (Medicine).

  Billing Provider Type:
  Physician (8) (31)
  Physician Assistant (18)
  Nurse Practitioner (19)
  Out-of-state, One Time Fee For Service Provider (73)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Urgent Care Facility (20)
  Federally Qualified Health Center (50)
  Community Mental Health Center (53)
  Rural Health Clinic (72)
  Other (99)

  Billing Unit: 15 minutes

- **H0020 HG – Alcohol and/or Drug Services; Methadone Administration and/or Services**: Administration of prescribed opioid agonist drugs for a person *to take at home* in order to reduce physical dependence on heroin and other opiate narcotics.

Providers must be AHCCCS registered as a Category of Services (COS) type 01 (Medicine).

Billing Provider Type:
Physician (8) (31)
Physician Assistant (18)
Nurse Practitioner (19)
Out-of-state, One Time Fee For Service Provider (73)

Place of Service:
Homeless Shelter (04)
Office (11)
Urgent Care Facility (20)
Outpatient Hospital (22)
Emergency Room – Hospital (23)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 1 dose per day (includes cost associated with drug and administration). While the billing unit is a single dose of medication per day, the take home medicine can be provided for more than one day.

Billing Limitations

For medication services the following billing limitations apply:

1. Medications provided in an inpatient general acute care or psychiatric hospital setting are included in the per diem rate and cannot be billed separately.

2. As described in the ADHS/DBHS Provider Manual Section 4.3, *Coordination of Care with AHCCCS Health Plans and PCPs,* in certain circumstances the person's primary care physician (PCP) may prescribe psychotropic medications (For the treatment of mild depression, anxiety and Attention-Deficit Hyperactivity Disorder). As such, care should be coordinated with other prescribers including AHCCCS Health Plan PCPs.

3. Other than opioid agonist (see limitation #4 below), the T/RBHA and/or provider should determine the maximum number of days and/or unit doses for prescriptions.

4. The Comprehensive Medication Services (Office) and Methadone Administration and/or Services (Take-Home) procedure codes are to be billed one dose per day (includes cost associated with drug and administration). Please note that while

the billing unit for Methadone Administration and/or Services (Take-Home) is a single dose of medication per day, the take home medicine can be provided for more than one day.

5. Transportation provided to the ADHS/DBHS person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

II. C. 2. Laboratory, Radiology and Medical Imaging

General Information

General Definition

Medical tests ordered for diagnosis, screening or monitoring of a behavioral health condition. This may include but is not limited to blood and urine tests, CT scans, MRI, EKG, and EEG.

Service Standards/Provider Qualifications

Laboratory, radiology, and medical imaging services may be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of his/her practice.

With the exception of specimen collections in a medical practitioner's office, laboratory services are provided in Clinical Laboratory Improvement Act (CLIA) approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4. (Also see requirements related to federal Clinical Laboratory Improvement Amendments in A.A.C. R9-14-101 and the federal code of regulations 42 CFR 493, Subpart A).

Radiology and medical imaging are provided in hospitals, medical practitioner's offices, and other health care facilities by qualified licensed health care professionals.

Code Specific Information

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION-Laboratory, Radiology and Medical Imaging
36415	Collection of venous blood by venipuncture
80048	Basic metabolic panel
80050	General health panel
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80061	Lipid panel

80076	Hepatic function panel
80100	Drug screen; multiple drug classes, each procedure
80101	Drug screen; single drug class, each drug class
80102	Drug, confirmation, each procedure
80152	Amitriptyline
80154	Benzodiazepines
80156	Carbamazepine
80160	Desipramine
80164	Valproic acid
80166	Doxepin
80174	Imipramine
80178	Lithium
80182	Nortriptyline
80299	Quantitation of psychotropic drug, NOS
80420	Dexamethasone suppression panel, 48 hour.
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, and any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, and any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, and any number of these constituents; non-automated, without microscopy
81003	Urinalysis, without microscopy

81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81025	Urine pregnancy test, by visual color comparison methods
81050	Volume measurement for timed collection, each
82055	Alcohol (ethanol), blood, urine
82075	Alcohol (ethanol); breath
82145	Amphetamine or methamphetamine, chemical, quantitative
82205	Barbiturate, not elsewhere specified
82382	Urinary catechloamines
82465	Cholesterol, serum or whole blood, total
82520	Cocaine, quantitative
82530	Cortisol, free
82533	Cortisol, total
82565	Creatinine; blood
82570	Creatinine (other than serum)
82575	Creatinine Clearance
82607	Cyanocobalamin (Vitamin B12)
82742	Flurazepam
82746	Folic Acid
82947	Glucose, quantitative, blood (except reagent strip)
82948	Glucose, blood, reagent strip
82977	Glutamyltransferase (GGT)
83840	Methadone

83925	Opiates (morphine, meperidine)
83992	Phencyclidine (PCP)
84022	Phenothiazines
84132	Potassium; blood
84146	Prolactin
84436	Thyroxine; total
84439	Thyroxine, free
84443	Thyroid stimulating hormone (TSH), RIA or EIA
84520	Urea nitrogen, blood (BUN); quantitative
84703	Gonadotropin, chorionic (HCG), qualitative
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
85008	Blood count; manual blood smear examination without differential parameters
85009	Blood count; differential WBC count, buffy coat
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit
85018	Blood count; hemoglobin, colorimetric
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85027	Blood count; hemogram and platelet count, automated
85048	White blood cell (WBC) count
85651	Sedimentation rate, erythrocyte; non-automated
85652	Sedimentation rate, erythrocyte; automated

86580	TB Test (PPD)
86592	Syphilis test; qualitative (eg, VDRL, RPR, ART)
86593	Syphilis test; quantitative
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, WES)
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single assay
87390	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-1
87391	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-2
70450	Computerized axial tomography, head or brain, without contrast material(s)
70460	Computerized axial tomography, head or brain; with contrast material(s)
70470	Computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections.
70551	Magnetic resonance imaging, brain; without contrast material.
70552	Magnetic resonance imaging, brain; with contrast material(s).
70553	Magnetic resonance imaging, brain; without contrast material, followed by contrast material(s) and further sequences.
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
93010	Electrocardiogram

93040	Rhythm ECG, one to three leads, with interpretation and report
93041	Rhythm ECG, one to three leads, tracing only
93042	Rhythm ECG, one to three leads, interpretation and report only
95819	Electroencephalogram (EEG) including recording awake and asleep, with hyperventilation and/or photic stimulation; standard or portable, same facility

Billing Limitations

For laboratory, radiology and medical imaging the following billing limitation applies:

Laboratory, radiology, and medical imaging services provided in an inpatient hospital setting are included in the per diem rate and cannot be billed separately.

II. C. 3. Medical Management

General Information

General Definition

Assessment and management services that are provided by a licensed medical professional (i.e., physician, nurse practitioner, physician assistant or nurse) to a person as part of his/her medical visit for ongoing treatment purposes. Includes medication management services involving the review of the effects and side effects of medications and the adjustment of the type and dosage of prescribed medications.

Service Standards/Provider Qualifications

Appropriately licensed physicians, nurse practitioners, physician assistants, and nurses must provide medical management services. Psychiatric consultation services are provided for AHCCCS primary care providers who wish to prescribe psychotropic medications in accordance with ADHS/DBHS Provider Manual Section 4.3, *Coordination of Care with AHCCCS Health Plans and PCPs.*. OBHL licensed agencies must operate within the scope of services authorized through the agency's license.

Code Specific Information

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION-Medical Management
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services.
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services.
90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services.

90811	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.
90813	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.
90815	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient.
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.
99201	Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and, straightforward medical decision-making. (Approx 10 min)
99202	Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: expanded problem-focused history; an expanded problem-focused exam; and straightforward medical decision-making. (Approx 20 min)
99203	Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision-making of low complexity. (Approx 30 min)
99204	Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity. (Approx 45 min)
99205	Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of high complexity. (Approx 60 min)
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a

	physician. Usually, the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. (Approx 10 min)
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; medical decision-making of low complexity. (Approx 15 min)
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision-making of moderate complexity. (Approx 25 min)
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. (Approx 40 min)
99304	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem and the patient's and/or family's needs. Usually the problem(s) requiring admission are of low severity.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually, the problem(s) requiring admission are of moderate severity.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination, and medical decision making of high complexity. Usually, the problem(s) requiring admission are of high severity.

99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Usually the patient is stable, recovering, or improving.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Usually, the patient has developed a significant complication or a significant new problem.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.
99315	Nursing facility discharge day management, 30 minutes or less.
99316	Nursing facility discharge day management, more than 30 minutes.
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity. Usually, the patient is stable, recovering, or improving. (Do not report 99318 on the same day of service as nursing facility services codes 99304-99316.)
99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.
99325	Domiciliary or rest home visit for the evaluation and management of

	a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.
99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.
99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination;

	medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; and medical decision making of moderate to high complexity. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.
99341	Home visit for the evaluation and management of a new patient which requires these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. (Approx 20 min).
99342	Home visit for the evaluation and management of a new patient which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. (Approx 30 min)
99343	Home visit for the evaluation and management of a new patient which requires 3 key components: a detailed history; a detailed examination; and decision-making of moderate complexity. (Approx 45 min).
99344	Home visit for the evaluation and management of a new patient, which requires these three components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. (Approx 60 min)
99345	Home visit for the evaluation and management of a new patient, which requires these three components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. (Approx 75 min)
99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem-focused examination; straightforward medical decision-making. (Approx 15 min)
99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an

	expanded problem focused interval history; an expanded problem focused examination; medical decision-making of low complexity. (Approx 25 min)
99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision-making of moderate complexity. (Approx 40 min)
99350	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision-making of moderate to high complexity. (Approx 60 min)
99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour. (List separately in addition to code for office or other outpatient evaluation and management service)
99355	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting). [Use for each additional 30 min in conjunction with 99354]
99358	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); first hour.
99359	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); [use for each additional 30 minutes in conjunction with 99358]
99499	Unlisted evaluation and management service.

<u>HCPCS Codes</u>

- **T1002 - RN Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider's scope of practice may include such activities as the

measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

Provider Qualifications:
Licensed registered nurse (within the scope of their license)

Billing Provider Type:
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Rural Substance Abuse Transitional Agency (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Custodial Care Facility (33)
Other (99)

Billing Unit: 15 minutes

- **T1003 – LPN Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider's scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

  Provider Qualifications:
  Licensed practical nurse (within the scope of their license)

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Rural Substance Abuse Transitional Agency (A6)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Home (12)
  Urgent Care Facility (20)
  Custodial Care Facility (33)
  Other (99)

  Billing Unit: 15 minutes

Billing Limitations

For medical management services the following billing limitations apply:

1. For RN and LPN Services (T1002 and T1003) see general core billing limitations in Section I.

2. Where applicable travel time by the provider is included in the rate for RN and LPN Services (T1002 and T003). See core provider travel billing limitations in Section I.

3. Nursing services provided in an OBHL licensed inpatient or residential setting or medical day program setting are included in the rate and cannot be billed separately.

4. Transportation provided to the ADHS/DBHS enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

II. C. 4. Electro-Convulsive Therapy

General Information

General Definition

The application of alternating current at or slightly above the seizure threshold through the use of electrodes attached to the scalp of a person who has received short-acting general anesthetic and muscle depolarizing medication.

Service Standards/Provider Qualifications

Electro-convulsive therapy services must be provided by a licensed physician with anesthesia support in a hospital.

Code Specific Information

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION-Electro-Convulsive Therapy
00104	Anesthesia for electroconvulsive therapy.
90870	Electroconvulsive therapy (includes necessary monitoring).

Revenue Codes

In addition to the CPT codes billed for the professional services, hospitals (02), free standing psychiatric facilities (71) or, subacute Facility (B5, B6) may bill **Revenue Code 0901** – electro-convulsive treatment for the facility-based costs associated with providing electro-convulsive therapy to a person in the facility. The rate for revenue code 0901 is set by report.

When electro-convulsive therapy is provided as part of an inpatient hospital admission, the following revenue codes are billed in addition.

0114 – Psychiatric; room and board – private
0124 – Psychiatric; room and board – semi private two beds
0134 – Psychiatric; room and board – semi private three and four beds
0154 – Psychiatric; room and board – ward.

II. D. Support Services

Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. These services have been grouped into the following categories:

- Case Management
- Personal Care Services
- Home Care Training Family Services (Family Support)
- Self-Help/Peer Services (Peer Support)
- HCTC
- Unskilled Respite Care
- Supported Housing
- Sign Language or Oral Interpretive Services
- Non-Medically Necessary Covered Services (Flex Fund Services)
- Transportation

II. D. 1. Case Management

General Information

General Definition

Case management is a supportive service provided to enhance treatment goals and effectiveness. Activities may include:

- Assistance in maintaining, monitoring and modifying covered services;
- Brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning;
- Assistance in finding necessary resources other than covered services to meet basic needs;
- Communication and coordination of care with the person's family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies;
- Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling);
- Outreach and follow-up of crisis contacts and missed appointments;
- Participation in staffings, case conferences or other meetings with or without the person or his/her family participating; and
- Other activities as needed.

Case management **does not** include:

- Administrative functions such as authorization of services and utilization review;
- Other covered services listed in the *ADHS/DBHS Covered Services Guide*.

Service Standards/Provider Qualifications

Case management services must be provided by individuals who are qualified *behavioral health professionals*, *behavioral health technicians*, *or behavioral health paraprofessionals* as defined in A.A.C. R9-20.

If case management services are not provided by the primary behavioral health professional or clinical liaison, these services must be provided under their direction or supervision.

Code Specific Information

CPT Codes

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.
90887	Interpretation or explanation of results of psychiatric, other medical exams & procedures, or other accumulated data to family/responsible person(s), or advising them how to assist or manage patient.
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than legal or consultative purposes) for other physicians, agencies, or insurance carriers.
99361	Medical team conference by a physician with an interdisciplinary team of health professionals or community agency representatives to coordinate client care. Approximately 30 minutes. (Client not present)
99362	Medical team conference by a physician with an interdisciplinary team of health professionals or community agency representatives to coordinate client care; client not present. Approximately 60 minutes.
99371	Telephone call by a physician or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists)
99372	Telephone call, intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem).
99373	Telephone call, complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services).

HCPCS Codes:

- **T1016 HO– Case Management by Behavioral Health Professional, Office :** Case management services (see general definition above for case management services) provided at the provider's work site.

Provider Qualifications:
Behavioral health professional

Billing Provider Type:
RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Licensed Clinical Social Worker (85)
Licensed Marriage/Family Therapist (86)
Licensed Professional Counselor (87)
Licensed Independent Substance Abuse Counselor (A4)

Place of Service:
Homeless Shelter (04)
Office (11)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)

Billing Unit: 15 minutes

- **T1016 HO – Case Management by Behavioral Health Professional, Out-of-Office:** Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.

  Provider Qualifications:
  Behavioral health professional

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Licensed Independent Substance Abuse Counselor (A4)

  Place of Service:
  Home (12)
  Outpatient Hospital (22)
  Emergency Room – Hospital (23)
  Other (99)

Billing Unit: 15 minutes

- **T1016 HN – Case Management, Office:** Case management services (see general definition above for case management services) provided at the provider's work site.

  Provider Qualifications:
  Behavioral health technician or Behavioral health paraprofessional

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Homeless Shelter (04)
  Office (11)
  Urgent Care Facility (20)
  Federally Qualified Health Center (50)
  Community Mental Health Center (53)
  State or Local Public Health Clinic (71)
  Rural Health Clinic (72)

  Billing Unit: 15 minutes

- **T1016 HN – Case Management, Out-of-Office:** Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.

  Provider Qualifications:
  Behavioral health technician or behavioral health paraprofessional

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Home (12)
  Outpatient Hospital (22)
  Emergency Room – Hospital (23)
  Other (99)

  Billing Unit: 15 minutes

Billing Limitations

For case management services the following billing limitations apply:

1. Case management services provided by an OBHL licensed inpatient or residential setting or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility or day program can bill case management services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.

2. The provider may not bill case management for any time associated with a therapeutic interaction nor simultaneously with any other services.

3. Multiple provider agencies may bill for this service during the same time period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service (e.g., individuals involved in transitioning a person from a residential level of care to a higher (subacute) or lower (outpatient) level of care, staff from each setting may bill case management when attending a staffing.

4. Billing for case management is limited to individual providers who are directly involved with service provision to the person (e.g., when a clinical team comprised of multiple providers physicians, nurses etc. meets to discuss current case plans, only team members who are directly involved with the person can bill for case management).

5. Transportation provided to an ADHS/DBHS enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

6. For Case Management codes:

    - See general core billing limitations in Section I
    - Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.
    - The provider should bill all time he/she spent in direct or indirect contact with the person, family and/or other parties involved in implementing the treatment/service plan. Indirect contact includes telephone calls, picking up and delivering medications, and/or collateral contact with the person, family and/or other involved parties.
    - Written electronic communication (email) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case management services and require specific documentation as specified below.

- Written electronic communication (email) must be about a specific individual and is allowable as case management, as long as documentation (a paper copy of the email) exists in the case record.
- When voice messages are used, the case manager must have sufficient documentation justifying a case management service was actually provided. Leaving a name and number asking for a return call is not sufficient to bill case management.
- When leaving voice messages, a signed document in the client chart granting permission to leave specific information would be required.

7. When a provider is picking up and dropping off medications for more than one behavioral health recipient, the provider must divide up the time spent and bill the appropriate case management code for each involved behavioral health recipient.

II. D. 2. Personal Care Services

General Information

General Definition

Personal care services involve the provision of support activities to assist a person in carrying out daily living tasks and other activities essential for living in a community. May include assistance with homemaking (e.g., cleaning, food preparation, essential errands), personal care (e.g., bathing, dressing, oral hygiene), and general supervision and appropriate intervention (e.g., assistance with self-administration of medications, and monitoring of individual's condition and functioning level). Services may involve hands-on assistance, such as performing the task for the person or cueing the person to perform the task. These services are provided to maintain or increase the self-sufficiency of the person.

Service Standards/Provider Qualifications

Personal care services may be provided by a licensed behavioral health agency utilizing individuals who are qualified as *behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals* as defined in A.A.C. R9-20.

Code Specific Information

HCPCS Codes

- **T1019 –Personal Care Services (Not for Inpatient or Residential Care Facilities):** Personal care services (see general definition above) provided to a person for a period of time (up to 11¾ hours).

Billing Provider Type:
Habilitation Provider (39)
RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State of Local Public Health Clinic (71)

Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **T1020 – Personal Care Services (Not for Inpatient or Residential Care Facilities):** Personal care services (see general definition above) provided to a person, for 12 or more hours.

Billing Provider Type:
Habilitation Provider (39)
RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: Per Diem

Billing Limitations

For personal care services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Personal care services provided in an OBHL licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately. This service is also included in the HCTC service rate and thus cannot be billed separately for persons receiving HCTC services.

4. Transportation (emergency and non-emergency) provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. Personal Care Services (T1019) and Personal Care Services (T1020) cannot be billed on the same day.

6. More than one provider agency may bill for personal care services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

II. D. 3. Home Care Training Family (Family Support)

General Information

General Definition

Home care training family services (family support) involve face-to-face interaction with family member(s) directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community. May involve support activities such as assisting the family to adjust to the person's disability, developing skills to effectively interact and/or manage the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family.

Service Standards/Provider Qualifications

Home care training family services (family support) must be provided by *behavioral health professionals, behavioral health technicians, or behavioral health para-professionals* as defined in A.A.C. R-9-20.

Code Specific Information

HCPCS Codes

- **S5110 –Home Care Training Family (Family Support):** See general definition above.

Billing Provider Type:
Habilitation Provider (39)
RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Licensed Clinical Social Worker (85)
Licensed Marriage/Family Therapist (86)
Licensed Professional Counselor (87)
Community Service Agency (A3)
Licensed Independent Substance Abuse Counselor (A4)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)

Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

Billing Limitations

For home care training family services (family support) the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Family support services provided in an OBHL licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately. This service is also included in the HCTC service rate and thus cannot be billed separately by the behavioral health therapeutic home. However, providers other than the inpatient, residential facility, day program or behavioral health therapeutic homes can bill home care training family services (family support) provided to the person residing in and/or transitioning out of the inpatient, residential settings or behavioral health therapeutic home or who is receiving services in a day program.

4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. More than one provider agency may bill for home care training family services (family support) services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

II. D. 4. Self-Help/Peer Services (Peer Support)

General Information

General Definition

Self-help/peer services are provided by persons or family members who are or have been consumers of the behavioral health system. This may involve assistance with more effectively utilizing the service delivery system (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers) or understanding and coping with the stressors of the person's disability (e.g., support groups), coaching, role modeling and mentoring.

Self-help/peer services are intended for enrolled persons and/or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups (e.g., AA, NA, Dual Recovery). These services may be provided to a person, group or family.

Service Standards/Provider Qualifications

Individuals providing self-help/peer services must be employed by or contracted with a Community Service Agency or a licensed facility allowed to bill the procedure code. Community Service Agencies providing this service must be Title XIX certified by ADHS.

Self-help/peer services may also be provided by a licensed behavioral health agency using, in addition to individuals who meet the qualifications above, individuals who are qualified as *behavioral health professionals, behavioral health technicians, or behavioral health para-professionals* as defined in A.A.C. R9-20.

Code Specific Information

HCPCS Codes

- **H0038 – Self-Help/Peer Services:** Self-help/peer services (see general definition above) provided to an individual person for a short period to time (less than 3 hours in duration).

Billing Provider Type:
RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Emergency Room – Hospital (23)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H0038 HQ – Self-Help/Peer Services - Group**: Self-help/peer services (see general definition above) provided to a group of persons and/or their families.

Billing Provider Type:
RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Emergency Room – Hospital (23)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H2016 – Comprehensive Community Support Services (Peer Support)**: Self-help/peer services (see general definition above) provided to a person for a period of time, which is 3 or more hours in duration.

Billing Provider Type:
RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)

Outpatient Clinic (77)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: Per Diem

Billing Limitations

For self-help/peer services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Self-help/peer services provided in an OBHL licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility or day program can bill self-help/peer services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.

4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. Self Help/Peer Services (H0038) and Comprehensive Community Support Services (H2016) cannot both be billed on the same day.

6. More than one provider agency may bill for self-help/peer services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

II. D. 5. Home Care Training to Home Care Client

General Information

General Definition

Home Care Training to Home Care Client (HCTC) services are provided by a foster parent/family to a person residing in his/her home in order to implement the in-home portion of the person's behavioral health service plan. HCTC services assist and support a person in achieving his/her service plan goals and objectives and also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services including personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the person when necessary to activities such as therapy and visitations and/or the participation in treatment and discharge planning.[4]

Service Standards/Provider Qualifications

Provider of Services to Children

Foster care families providing HCTC services to children must meet the following qualifications:

- Be a DES licensed professional foster care home (R6-5-5850); or
- Be licensed by federally recognized Indian Tribes that attest to CMS (via AHCCCS) that they meet equivalent requirements.

Provider of Services to Adults

Foster care families providing HCTC services to adults must meet the following qualifications:

- Be an OBHL licensed Adult Therapeutic Foster Home (R9-20-1501 *et seq.*); or

[4]The following exception applies:
Based on behavioral health recipient needs, the following support services may be provided and billed on the same day that HCTC services are provided:

- Personal Care Services (T1019)
- Skills Training and Development (H2014/H2014HQ)
- Home Care Training Family Services (S5110)
- Self-help /Peer Services (H0038)
- Psychosocial Rehabilitation Services (H2017)

The support services indicated above may be billed on the same day as HCTC services through a manual over-ride process. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

- Be licensed by federally recognized Indian Tribes that attest to CMS (via AHCCCS) that they meet equivalent requirements.

For all providers of HCTC services, prior to providing a service for either an adult or child, the T/RBHAs must ensure that:

a. The behavioral health therapeutic home providers have successfully completed pre-service training in the type of care and services required for the individual being placed in the home.

b. The behavioral health therapeutic home providers have access to crisis intervention and emergency consultation services.

c. A Clinical Supervisor has been assigned to oversee the care provided by the therapeutic foster care home.

Code Specific Information

HCPCS Codes

- **S5109 HB–Home Care Training to Home Care Client, per session (Adult)**
- **S5109 HC-Home Care Training to Home Care Client, per session (Adult geriatric)**
- **S5109 HA-Home Care Training to Home Care Client, per session (Child)**

Billing Provider Type:
Behavioral Health Therapeutic Home (A5)

Place of Service:
Home (12)
Other (99)

Billing Unit: Per diem

Billing Limitations

For HCTC services the following billing limitations apply:

1. Personal care services, skills training and development and home care training family services (family support) are provided by the therapeutic foster care employee and are included in the HCTC rate. All other counseling, evaluation, support and rehabilitation services provided to the ADHS/DBHS member may be billed using the appropriate procedure code.

2. The HCTC procedure code does not include any professional services; therefore, professional services provided should be billed by the appropriate provider using the appropriate CPT codes.

3. The HCTC procedure code does not include day program services, this service should be billed by the appropriate provider using the appropriate procedure code.

4. Room and board services are to be billed separately. The State-funded HCPCS code for room and board is to be used for all persons except for state-placed children (i.e., DES or AOC) whose room and board should be paid by the placing agency.

5. A licensed professional who supervises and trains the therapeutic foster care family may not bill these functions. Employee supervision and training has been built into the procedure code rate.

6. Pre-training activities associated with the HCTC setting is included in the rate. This service may not be billed outside the HCTC procedure code rate by either the licensed professional or therapeutic foster care family.

7. Prescription drugs are not included in the rate and should be billed by appropriate providers using the appropriate NDC procedure codes.

8. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.

9. Emergency transportation provided to an ADHS/DBHS member is not included in the rate and should be billed separately by the appropriate provider using the appropriate transportation procedure codes.

10. Non-emergency transportation is included in the rate and cannot be billed separately.

11. Any medical services provided to persons, excluding those medical services included in the ADHS/DBHS covered service array as set forth in this guide should be billed to the member's health plan.

12. HCTC Services cannot be encountered/billed on the same day as service code S5151, Unskilled respite care, not hospice; per diem.

II. D. 6. Unskilled Respite Care

General Information

General Definition

Respite services involve the supervision and/or care of persons residing at home in order to provide an interval of rest and/or relief to the person and/or their primary care givers and may include a range of activities to meet the social, emotional and physical needs of the person during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays.

Respite services can be planned or unplanned. If unplanned respite is needed, the appropriate agency personnel will assess the situation and, with the caregiver, recommend the appropriate setting for respite.

The tasks of the respite provider may include:

- Securing all medical releases and instructions for care from the family/caregiver
- Providing supervision for the period of time authorized
- Ensuring that medications are taken as prescribed
- Providing first aid and appropriate attention to illness and injury
- Providing for the appropriate nutritional needs of the person
- Providing transportation to regularly scheduled programs and appointments - including school or work as appropriate. [Transportation provided must be in appropriately licensed, safe vehicles equipped with required restraints (seat belts, car seats) and safety equipment (wheel chair lock downs). A.R.S. 28-4009]
- Reporting any accidents or unusual incidents to ADHS/DBHS/RBHA (on required forms)

Regardless of the provider type, respite services can be provided in a facility or in a home setting (either a provider's home or the person's home). The setting in which respite services are received should be the most conducive to the person's situation. When respite services are provided in a home setting, household routines and preferences should be respected and maintained when possible. It is essential that the respite provider receive orientation from the family/caregiver regarding the person's needs as well as the person's individual service plan. At all times the respite provider shall respect and maintain the confidentiality of the family/caregiver.

Respite services, including the goals, setting, frequency, duration and intensity of the service, are defined in the person's service plan. Respite services are not a substitute for other medically necessary covered services. The treatment team will also explore the availability and use of informal supports and other community resources to meet the caregiver's respite needs.

Summer day camps, day care or other ongoing, structured activity programs are not respite unless they meet the definition/criteria of respite services and the provider qualifications.

Parents receiving behavioral health services may receive necessary respite services for their non-enrolled children as indicated in their service plan. Non-enrolled siblings of a child receiving respite services are not eligible for behavioral health respite benefits.

Service Standard/Provider Qualifications

Respite services may be provided in a variety of settings. Each provider type must meet the appropriate licensing or certification requirements. The type of setting in which respite services are provided must ensure that the person's current service plan can be appropriately supported and that the services provided are within the respite provider's qualifications and experience.

Respite provider's specific qualifications and competencies must include:

- CPR and first aid certification;
- Medical documentation of freedom from tuberculosis;
- Behavioral health orientation, training and supervision:
  - Orientation includes: client rights, confidentiality, behavioral health symptoms, managing safety, protecting member dignity and choice etc.;
  - Additional training and supervision includes: behavioral management techniques, stages of development, behavioral health issues, crisis identification and referral and other population specific information needed to continue the individual's service goals and to promote the health, safety and personal dignity of the person;
  - Compliance with any additional training requirements outlined in *ADHS/DBHS Policy MI 5.2Community Service Agencies—Title XIX Certification*; and
  - Access to regular in-service training, administrative contact and peer support.
- When respite services are provided in an outpatient facility or in a provider's home, the following apply:
  - If a facility or home inspection has not been done as part of the licensing or certification process, the RBHA must inspect the facility or home; and
  - If providing services to persons less than 18 years of age, any persons residing in the home that are 18 years or older must be fingerprinted in accordance with A.R.S. 36-425.03.

Code Specific Information

<u>Revenue Codes</u>

Respite services provided in an OBHL licensed Level I facility should be billed using the appropriate revenue codes listed in Section II. F. Inpatient Services for the facility type.

HCPCS Codes

- **S5150– Unskilled Respite (not hospice):** Unskilled respite services (see general definition above) provided to a person for a short period of time (up to 12 hours in duration).

  Billing Provider Type:
  Habilitation Provider (39)
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Level II (74)
  Community Service Agency (A3)
  Level III (A2)
  Behavioral Health Therapeutic Home (A5)

  Place of Service:
  Home (12)
  Other (99)

  Billing Unit: 15 minutes

- **S5151– Unskilled Respite – (not hospice):** Unskilled respite services provided to a person for more than 12 hours in duration.

  Billing Provider Type:
  Habilitation Provider (39)
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Level II (74)
  Level III (A2)
  Community Service Agency (A3)
  Behavioral Health Therapeutic Home (A5)

  Place of Service:
  Home (12)
  Other (99)

  Billing Unit: Per Diem

Billing Limitations

For respite services, the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Respite services billed using the two HCPCS codes are limited to no more than 30 days or 720 hours of respite services per contract year (July 1st through June 30th) per person. RBHAs must ensure the accurate tracking of respite service limitations for their enrolled members.

3. For Level II and Level III facilities providing respite services, room and board may be billed in addition to the per diem rate.

4. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

5. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

6. Respite services cannot be billed for persons who are residing and receiving treatment in an OBHL licensed Level I, II or III facility, DES group home or nursing home.

II. D. 7. Supported Housing

General Information

General Definition

Supported housing services are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes that are owned or leased by a subcontracted provider. These services may include rent and utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.

Service Standards/Provider Qualifications

Supported housing services are provided by *behavioral health professionals*, *behavioral health technicians* or *behavioral health paraprofessionals*. Staff providing the services must have knowledge of state and local landlord/tenant laws.

Code Specific Information

State Funded HCPCS Codes:

- **H0043 – Supported Housing**

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Community Service Agency (A3)

  Place of Service:
  Home (12)
  Other (99)

  Billing Unit. Per Diem

Billing Limitations

For supported housing services the following billing limitations apply:

1. Supported housing services do not include meals, furnishing(s) or other household equipment. (See Flex Fund Services). The T/RBHA must monitor to ensure the proper use of this service code.

2. Direct payment for supported housing services to the behavioral health recipient and/or his/her family are not permitted.

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II. D. 8. Sign Language or Oral Interpretive Services

General Definition

Sign language or oral interpretive services provided to persons and/or their families with limited English proficiency or other communication barriers (e.g. sight or sound) during counseling or other treatment activities that will allow the person to obtain maximum benefit from the services.

Service Standards/Provider Qualifications

Sign language or oral interpretive services must be provided by staff interpreters, contract interpreters, or through a telephone service from an individual behavioral health provider's office, agency, or facility. Providers of sign language or oral interpretive services do not need to be registered with AHCCCS but must bill through AHCCCS registered providers. Interpreters of any language must be available free of charge to Title XIX/XXI eligible persons to ensure appropriate delivery of covered behavioral health services.

Code Specific Information

State Funded HCPCS Codes

- **T1013 –Sign Language or Oral Interpretive Services:** (see general definition above)

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Community Service Agency (A3)
  Rural Substance Abuse Transitional Agency (A6)
  Other (S2)
  Tribal Traditional Service Practitioner (S3)

  Place of Service:
  Office (11)
  Home (12)
  Outpatient Hospital (22)
  Federally Qualified Health Center (50)
  Community Mental Health Center (53)
  Residential Substance Abuse Treatment Facility (55)
  State or Local Public Health Clinic (71)
  Rural Health Clinic (72)
  Other (99)

Billing Unit: Not applicable

For interpreter services the following billing limitations apply:

1. The sign language or oral interpretive service code must be billed in combination with a code for a behavioral health service that cannot be delivered effectively without the availability of sign language or interpreter services.

2. For OBHL licensed inpatient and residential facilities, sign language or oral interpretive services are included in the per diem rate and should not be billed separately by the facility.

II. D. 9. Non-Medically Necessary Covered Services

General Information

General Definition

Non-medically necessary covered services or "flex funds" refers to funding designated for the uses described in this section. T/RBHAs may access flex funds to purchase any of a variety of one-time or occasional goods and/or services needed for enrolled persons (children or adults) and their families, when the goods and/or services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled person's service plan. Additionally, "flex funds" include the Arizona State Hospital (ASH) Transition Fund, which provides living support and assistance to T/RBHA enrolled adults diagnosed with a serious mental illness and TXIX/XXI eligible children with serious emotional disturbance who are discharged from the Arizona State Hospital (Civil and Adolescent Units). The funds are intended to promote wellness, comfort and safety for vulnerable children and adults returning to the community in a respectful, individualized manner. Refer to ADHS/DBHS Policy and Procedures Manual Section MI 5.4, Arizona State Hospital Transition Fund for specific information.

Non-medically necessary covered services and/or supports (flex funds) must be described in the person's service plan, and must be related to one or more of the following outcomes: a.) success in school, work or other occupation; b.) living at the person's own home or with family; c.) development and maintenance of personally satisfying relationships; d.) prevention of or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation; and/or e.) becoming or remaining a stable and productive member of the community.

Program Standards/Provider Qualifications

In consideration with other available resources, the clinical liaison, behavioral health representative on the team or service provider may approve flex fund expenditures as permitted by the T/RBHA.

Code Specific Information

State Funded HCPCS Code:

- **S9986 –Non-Medically Necessary Services (Flex Fund Services)**

Billing Provider Type:
RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Community Service Agency (A3)

Place of Service:
Office (11)
Home (12)
Outpatient Hospital (22)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
Residential Substance Abuse Treatment Facility (55)
State of Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: Not applicable

- **S9986 HW–Medicare Part D Premium (Not considered use of flex funds)**

Billing Provider Type:
Level I Hospital (02)
Pharmacy (03)
Laboratory (04)
Emergency Transportation (06)
Physician (08)
Psychologist (11)
Physician Assistant (18)
Nurse Practitioner (19)
Non-emergency Transportation (28)
Physician (Osteopathic) (31)
Habilitation Provider (39)
Level I Psychiatric Hospital (IMD) (71)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Level II Behavioral Health Residential (non-IMD) (74)
Outpatient Clinic (77)
Level I Residential Treatment Center – Secure (non-IMD) (78)
Licensed Clinical Social Worker (85)
Licensed Marriage / Family Therapist (86)
Licensed Professional Counselor (87)
Air Transport Providers (97)
Level III Behavioral Health Residential (non-IMD) (A2)
Community Service Agency (A3)
Licensed Independent Substance Abuse Counselor (A4)
Behavioral Health Therapeutic Home (A5)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center – Secure (IMD) (B1)
Level I Residential Treatment Center – Non-Secure (non-IMD) (B2)
Level I Residential Treatment Center – Non-Secure (IMD) (B3)
Level I Subacute Facility (non-IMD) (B5)

Level I Subacute Facility (IMD) (B6)
Level I Crisis Services (B7)
Other (S2)
Tribal Traditional Service Practitioner (S3)

Place of Service:
Office (11)
Home (12)
Outpatient Hospital (22)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
Residential Substance Abuse Treatment Facility (55)
State of Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: One (1) per month per recipient

Billing Limitations for Medicare Part D Premium (Not considered use of flex funds)

T/RBHAs will use state funds to pay the Medicare Part D premium for dual eligibles and behavioral health recipients determined to have a Serious Mental Illness (SMI) who are unable to make his/her premium payment in accordance with Provider Manual Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding. ADHS is allowing the use of state funds for this purpose to ensure that behavioral health recipients maintain access to prescription drug coverage through Medicare Part D.

Encounters for coverage of a Part D premium will be done on a CMS 1500 form using code S9986 HW (Not medically necessary services) with the "HW" (funded by state mental health agency) modifier.

Billing Limitations for "flex funds"

For Non-Medically Necessary Covered Services or "flex funds" the following billing limitations apply:

1. Non-Medically Necessary Covered Services are subject to availability of funds.

2. T/RBHAs shall establish procedures for approval of flex fund expenditures, and may allow approval directly by the treatment team. T/RBHAs shall also establish procedures for maintenance of documentation of flex fund expenditures.

3. ADHS/DBHS must give its prior approval of requests for flex funds exceeding $1,525 per individual per fiscal year.

4. Non-Medically Necessary Covered Services may not be used to provide inpatient or any other covered behavioral health services. T/RBHAs and their treatment teams must attempt to identify alternative funding/resources prior to approving the expenditure of flex funds. (Examples of alternative funding/resources might include: state, federal or tribal funds; family resources; donations; and community funds)

5. Direct cash payments to the person and/or his/her family are not permitted.

6. Non-Medically Necessary Covered Services may not be used to: a.) purchase or improve land; b.) purchase, construct or permanently improve any building or other facility; or c.) purchase major medical equipment. Non-Medically Necessary Covered Services may, however, be used to pay for minor remodeling consistent with these guidelines.

II. D. 10. Transportation

General Information

General Definition

Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, covered behavioral health services, allowing the person to achieve his/her service plan goals. The service may also include the transportation of a person's family/caregiver with or without the presence of the person, if provided for the purposes of carrying out the person's service plan (e.g., counseling, family support, case planning meetings). Urban transports are defined as those originating within the Phoenix or Tucson metropolitan areas. All other transports are defined as rural.

Service Standards/Provider Qualifications

Transportation services may be provided by:

- Non-emergency transportation providers (e.g., vans, buses, taxis) who are registered with AHCCCS as a non-emergency transportation provider and have proof of insurance, drivers with valid driver's licenses and any other insurance as required by state law.
- Emergency transportation providers (e.g., air or ground ambulance) who are registered with AHCCCS as emergency transportation providers and have been granted a certificate of necessity by the Arizona Department of Health Services / Bureau of Emergency Medical Services (A.R.S. 36-2222 et seq.).

In most instances, transportation services should be provided by non-emergency transportation providers. Transportation services furnished by a ground or air ambulance provider should be provided in situations in which the person's condition is such that the use of any other method of transportation is contraindicated and medically necessary behavioral health services are not available in the hospital from which the person is being transported.

Emergency transportation service shall not require prior authorization.

Non-emergency transportation must be provided for persons and/or families who are unable to arrange or pay for their transportation or who do not have access to free transportation in order to access medically necessary covered behavioral health services.

Code Specific Information

HCPCS Codes-Emergency Transportation Providers Only

- **A0382 – BLS routine disposable supplies**

- **A0398 – ALS routine disposable supplies**
- **A0420 - Ambulance (ALS or BLS), ½ hour increments**
- **A0422 – Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation (BR)**

Billing Provider Type:
Emergency Transportation (06)
Out-of-state, One Time Fee For Service Provider (73)

Place of Service:
Ambulance – Land (41)
Ambulance – Air or Water (42)

- **A0888 – Non-covered ground ambulance mileage, per mile**

Billing Provider Type:
Emergency Transportation (06)
Out-of-state, One Time Fee For Service Provider (73)
Air Transport Providers (97)

Place of Service:
Ambulance – Land (41)
Ambulance – Air or Water (42)

- **A0426 – Ambulance service, ALS; non-emergency transport, level 1 (ALS 1)**
- **A0427 – Ambulance service, ALS; emergency transport, level 1**
- **A0428 – Ambulance service, basic life support base rate, non-emergency transport (BLS)**
- **A0429 – Ambulance service, basic life support base rate, emergency transport (BLS)**
- **A0434 – Specialty Care Transport (SCT) (this code may be used only by TRBHAs)**

Billing Provider Type:
Emergency Transportation (06)
Out-of-state, One Time Fee For Service Provider (73)

Place of Service:
Ambulance – Land (41)
Ambulance – Air or Water (42)
Other (99)

- **A0430 – Ambulance service, conventional air services, transport, one-way (fixed wing)**
- **A0431 – Ambulance service, conventional air services, transport, one way (rotary wing)**
- **A0435 – Fixed wing air mileage, per statute mile**
- **A0436 – Rotary wing air mileage, per statute mile**

Billing Provider Type:
Out-of-state, One Time Fee For Service Provider (73)
Air Transport Providers (97)

Place of Service:
Ambulance – Air or Water (42)
Other (99)

HCPCS Codes-Non-Emergency Transportation Providers Only

- **A0090* – Non-emergency transportation, per mile, vehicle provided by individual (family, neighbor, etc.) with vested interest**

Billing Provider Type:
Emergency Transportation (06)
Non-emergency Transportation (28)
Habilitation Provider (39)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Level I Residential Treatment Center-Secure (78) (B1)
Community Service Agency (A3)
Level I Residential Treatment Center-Non-Secure (B2) (B3)
Level I Subacute Facility (B5) (B6)
Level I Crisis Services (B7)

Place of Service:
Other (99)

*This code must be used by friends/relatives/neighbors when transporting a client.

- **A0100 – Non-emergency transport; taxi, intra-city, base rate**
- **A0110 – Non-emergency transport via intra- or interstate carrier (may be used to encounter and/or bill for bus passes)**

Billing Provider Type:
Emergency Transportation (06)
Non-emergency Transportation (28)
Habilitation Provider (39)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Other (99)

- **A0170 – Non-emergency transport; ancillary services-parking fees, tolls, other**
- **A0180 – Non-emergency transport; ancillary services-lodging-recipient**
- **A0190 – Non-emergency transport; ancillary services-meals-recipient**
- **A0200 – Non-emergency transport; ancillary services-lodging-escort**
- **A0210 – Non-emergency transport; ancillary services-meals-escort**

Billing Provider Type:
Emergency Transportation (06)
Non-emergency Transportation (28)
Habilitation Provider (39)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Ambulance – Land (41)
Ambulance – Air or Water (42)
Other (99)

- **A0120* – Non-emergency transportation; mini-bus, mountain area transports**

Billing Provider Type:
Level I Hospital (02)
Non-emergency Transportation (28)
Habilitation Provider (39)
Level I Psychiatric Hospital (71)

T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)

Outpatient Clinic (77)
Level I Residential Treatment Center-Secure (78) (B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center-Non-Secure (B2) (B3)
Level I Subacute Facility (B5) (B6)
Level I Crisis Services (B7)

Place of Service:
Other (99)

*This code may be used for vans or cars.

- **A0120 TN* - Non-emergency transportation; mini-bus, mountain area transports**

Billing Provider Type:
Level I Hospital (02)
Non-emergency Transportation (28)
Habilitation Provider (39)
Level I Psychiatric Hospital (71)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Level I Residential Treatment Center-Secure (78) B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center-Non-Secure (B2) (B3)
Level I Subacute Facility (B5) (B6)
Level I Crisis Services (B7)

Place of Service:
Other (99)

* This code may be used for vans or cars.

A0130 – Non-emergency transport; wheel-chair van, base rate

Billing Provider Type:
Emergency Transportation (06)
Non-emergency Transportation (28)
Habilitation Provider (39)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)

Level I Residential Treatment Center-Secure (B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center-Non-Secure (B2) (B3)

Place of Service:
Other (99)

- **A0130 TN – Non-emergency transport; wheel-chair van, base rate**

Billing Provider Type:
Level I Hospital (02)
Emergency Transportation (06)
Non-emergency Transportation (28)
Habilitation Provider (39)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Level I Residential Treatment Center-Secure (B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center-Non-Secure (B2) (B3)

Place of Service:
Other (99)

- **A0140 – Non-emergency transport; and air travel (private or commercial), intra- or interstate**

Billing Provider Type:
Non-emergency Transportation (28)
Habilitation Provider (39)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Air Transport Providers (97)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Place of Service:
Ambulance – Land (41)
Ambulance – Air or Water (42)
Other (99)

- **A0160 – Non-emergency transport; mile-case worker or social worker**

  Billing Provider Type:
  Emergency Transportation (06)
  Non-emergency Transportation (28)
  Habilitation Provider (39)
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Licensed Clinical Social Worker (85)
  Licensed Marriage/Family Therapist (86)
  Licensed Professional Counselor (87)
  Community Service Agency (A3)
  Licensed Independent Substance Abuse Counselor (A4)
  Rural Substance Abuse Transitional Center (A6)

  Place of Service:
  Ambulance – Land (41)
  Ambulance – Air or Water (42)
  Other (99)

- **T2003 – Non-emergency transportation; encounter/trip**

  Billing Provider Type:
  Non-emergency Transportation Providers (28)
  Out-of-state, One Time Fee For Service Provider (73)
  Air Transport Providers (97)

  Place of Service:
  Other (99)

HCPCS Codes-Emergency and Non-emergency Transportation Providers

- **S0209 – Wheelchair van mileage, per mile**

  Billing Provider Type:
  Level I Hospital (02)
  Emergency Transportation (06)
  Non-emergency Transportation Providers (28)
  Level I Psychiatric Hospital (71)
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

Level I Residential Treatment Center-Secure (78) (B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center-Non-Secure (B2) (B3)

Place of Service:
Other (99)

- **S0215 – Non-emergency transportation mileage, per mile**

Billing Provider Type:
Level I Hospital (02)
Emergency Transportation (06)
Non-emergency Transportation Providers (28)
Habilitation Provider (39)
Level I Psychiatric Hospital (71)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Level I Residential Treatment Center-Secure (78) (B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center-Non-Secure (B2) (B3)
Level I Subacute Facility (B5) (B6)
Level I Crisis Services (B7)

Place of Service:
Other (99)

- **S0215 TN – Non-emergency transportation mileage, per mile**

Billing Provider Type:
Level I Hospital (02)
Emergency Transportation (06)
Non-emergency Transportation Providers (28)
Habilitation Provider (39)
Level I Psychiatric Hospital (71)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Level I Residential Treatment Center-Secure (78) (B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)

Level I Residential Treatment Center-Non-Secure (B2) (B3)
Level I Subacute Facility (B5) (B6)
Level I Crisis Services (B7)

Place of Service:
Other (99)

- **T2005 – Non-emergency transportation, non-ambulatory stretcher van**

Billing Provider Types:
Hospital (02)
Emergency Transportation (06)
Non-Emergency Transportation Providers (28)
Level I Psychiatric Hospital (71)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Level I Residential Treatment Center-Secure (78) (B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center-Non-Secure (B2) (B3)

Place of Service:
Other (99)

- **T2005 TN - Non-emergency transportation, non-ambulatory stretcher van**

Billing Provider Type:
Hospital (02)
Emergency Transportation (06)
Non-Emergency Transportation Providers (28)
Level I Psychiatric Hospital (71)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Level I Residential Treatment Center-Secure (78) (B1)
Community Service Agency (A3)
Rural Substance Abuse Transitional Center (A6)
Level I Residential Treatment Center-Non-Secure (B2) (B3)

Place of Service:
Other (99)

- **T2007 – Transportation waiting time, air ambulance and non-emergency vehicle**

  Billing Provider Type:
  Non-Emergency Transportation Providers (28)
  Habilitation Provider (39)
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Community Service Agency (A3)
  Rural Substance Abuse Transitional Center (A6)
  Level I Residential Treatment Center-Secure (78) (B1)
  Level I Residential Treatment Center-Non-Secure (B2) (B3)

  Place of Service:
  Other (99)

- **A0425 – Ground mileage, per statute mile**

  Billing Provider Type:
  Emergency Transportation (06)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Ambulance-Air or Water (42)
  Ambulance-Land (41)
  Other (99)

- **T2049 – Non-emergency transportation; stretcher van, mileage; per mile**
- **T2049 TN - Non-emergency transportation; stretcher van, mileage; per mile**

  Billing Provider Type:
  Hospital (02)
  Emergency Transportation (06)
  Non-Emergency Transportation Providers (28)
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)

  Place of Service:
  Other (99)

- **A0999 – Unlisted ambulance service. Determine if an alternative national HCPCS Level II code or a CPT code better describes the service. This code should be used only if a more specific code is unavailable.**

Billing Provider Type:
Emergency Transportation (06)
Non-Emergency Transportation Providers (28)
T/RBHA (72)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Air Transport Providers (97)
Community Service Agency (A3)

Place of Service:
Ambulance – Land (41)
Ambulance – Air or Water (42)
Other (99)

Billing Limitations

For transportation services the following billing limitations apply:

1. See core transportation billing limitations in Section I.

2. Emergency transportation required to manage an emergency medical condition and which includes the transportation of a person to the same or higher level of care for immediate medically necessary treatment at the nearest appropriate facility is covered for AHCCCS members and is the responsibility of the AHCCCS contracted Health Plan.

3. Depending on the setting and the service being provided, certain transportation costs may be included as part of a provider's rate and can not be billed separately.

4. Like all other non-emergency transportation, A0090 may only be billed if a person and/or family is unable to arrange or pay for their transportation or does not have access to free transportation in order to access medically necessary covered behavioral health services.

5. When providing transportation to multiple clients, the provider bills a base rate for each client and the loaded mileage for each person transported. Loaded mileage is the actual number of miles each enrolled person is transported in the vehicle beginning with the odometer reading when the enrolled person is picked up and ending with the odometer reading when the enrolled person is dropped off.

6. For most transports, the provider should bill the appropriate base rate code and the number of loaded miles using the appropriate mileage code. Loaded mileage is the distance traveled while a person and/or family is being transported.

7. The following provider types may bill A0120, S0215, S0215 TN or A0120 TN, when providing crisis intervention – (H2011 HT) or crisis intervention service via two-person team or crisis intervention service (H2011):
   -Hospital (02)
   -Psychiatric Hospital (71)
   -Out-of-state, One Time Fee For Service Provider (73)
   -Outpatient Clinic (77)
   -Level I Subacute Facility (non-IMD) (B5)
   -Level I Subacute Facility (IMD) (B6)
   -Crisis Services Provider (B7)

8. More than one provider agency may bill for transportation services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs

9. A provider may bill for transportation services provided to a behavioral health recipient in order to receive a Medicare covered service.

II. E. Crisis Intervention Services

Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially deleterious behavioral health condition, episode or behavior. Crisis intervention services are provided in a variety of settings including but not limited to a person's place of residence, other community sites, OBHL licensed facilities or over the telephone. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) assessment, evaluation or counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation.

Behavioral health crisis intervention services provided to Title XIX and Title XXI members are always the responsibility of the T/RBHA except in the following situations:

- For persons not yet enrolled with a T/RBHA, the AHCCCS health plan is responsible for up to 72 hours of inpatient psychiatric care not to exceed 12 days per contract year.
- For persons not yet enrolled with a T/RBHA, the AHCCCS health plan is responsible to pay for psychiatric or psychological consults provided in an emergency room. (For persons who are enrolled with a T/RBHA, the T/RBHA is responsible to pay for psychiatric or psychological consults provided in an emergency room). The AHCCCS health plan is responsible for paying for all the medical services in the emergency room regardless of the person's enrollment status with a T/RBHA.

Many types of services throughout this Covered Behavioral Health Services Guide may be billed when providing crisis intervention services (e.g. screening, counseling and therapy, case management). This section describes codes for additional crisis intervention services.

CPT Codes:

CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to ***Appendix B.2. –Allowable Procedure Code Matrix*** to identify providers who can bill using CPT codes.

CODE	DESCRIPTION-Crisis Services
99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making. Presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination;

	and medical decision-making for a problem of low complexity. Presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making for a problem of moderate complexity. Presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. Presenting problem(s) are of high severity.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision- making of high complexity. Presenting problem(s) are of high severity.

II. E. 1. Crisis Intervention Services (Mobile)

General Information

General Definition

Crisis intervention services provided by a mobile team or individual who travels to the place where the person is having the crisis (e.g., person's place of residence, emergency room, jail, community setting). Crisis intervention services include risk analysis, assessment, and crisis counseling services, de-escalation, critical incident debriefing, and consultation, if necessary with a higher-level behavioral health professional. Depending on the situation, the person may be transported to a more appropriate facility for further care. (e.g., a crisis services center)

Service Standards/Provider Qualifications

Crisis intervention services must be provided by agencies that have an OBHL license.

Wherever possible, the two-person crisis team should consist of a behavioral health professional and a behavioral health technician. In some situations (e.g., the safety of staff and control of the environment are not primary concerns, such as in hospitals, schools, residential settings) it may only be necessary to send a single individual out to intervene. Depending on the acuity of the person, the crisis intervention services may be provided by either a qualified behavioral health professional or behavioral health technician.

All individuals providing this service must at a minimum have been trained in first aid, CPR and non-violent crisis resolution. Additionally, individuals must have valid Arizona driver licenses and vehicles used must be insured as required by Arizona law.

The T/RBHA or applicable provider agency must ensure that:

- Individuals providing this service have a means of communication, such as a cellular phone, pager, or radio for dispatch, that is available at all times.
- On-call behavioral health professionals are available 24 hours a day for direct consultation.
- If transporting persons, the requirements specified in A.A.C. R9-20 (outings and transportation) are met.

Code Specific Information

- **H2011 HT – Crisis Intervention Service – via two-person team:** See general definition above.

  Billing Provider Type:

Psychiatric Hospital (71)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Subacute Facility (B5, B6)
Crisis Services Provider (B7)

Place of Service:
Homeless Shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Emergency Room – Hospital (23)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H2011 – Crisis Intervention Service –** See general definition above.

Billing Provider Type:
Psychiatric Hospital (71)
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)
Subacute Facility (B5) (B6)
Crisis Services Provider (B7)

Place of Service:
Homeless shelter (04)
Office (11)
Home (12)
Urgent Care Facility (20)
Emergency Room – Hospital (23)
Federally Qualified Health Center (50)
Community Mental Health Center (53)
State or Local Public Health Clinic (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

Billing Limitations

For crisis intervention services (mobile) the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Billing for this service should not include mobile crisis response services provided by fire, police, EMS, and other providers of public health and safety services.
3. Transportation provided to the person receiving the crisis intervention services is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Services provided in the jail setting are not Title XIX/XXI reimbursable.

II. E. 2. Crisis Intervention Services (Stabilization)

General Information

General Definition

Crisis intervention services (stabilization) are provided in order to stabilize and/or resolve the behavioral health crisis situation and may include crisis triage, assessment and counseling services, medical services (including detoxification), nursing services, medication and medication monitoring, and the development of a discharge plan. Persons may walk-in or may be referred/transported to these settings.

Provider Standards/Service Standards

Crisis intervention services (stabilization) must be provided by facilities that are OBHL licensed Level I facilities (excluding residential treatment centers). Individuals providing these services must be *behavioral health professionals, behavioral health technicians or behavioral health para-professionals* as defined in A.A.C. R9-20.

Lab, radiology and psychotropic medications may be provided by an AHCCCS registered provider if prescribed by a qualified practitioner.

Code Specific Information

HCPCS Codes

- **S9484 – Crisis Intervention Mental Health Services – (Stabilization)** See definition above. Up to 5 hours in duration.

  Billing Provider Type:
  Hospital (02)
  Psychiatric Hospital (71)
  Out-of-state, One Time Fee For Service Provider (73)
  Subacute Facility (B5) (B6)
  Crisis Services Provider (B7)

  Place of Service:
  Inpatient Hospital (21)
  Inpatient Psychiatric Facility (51)
  Other (99)

  Billing Unit: One hour

- **S9485 – Crisis Intervention Mental Health Services – Stabilization)** See definition above. More than 5 hours and up to 23 hours in duration.

Billing Provider Type:
Hospital (02)
Psychiatric Hospital (71)
Out-of-state, One Time Fee For Service Provider (73)
Subacute Facility (B5) (B6)
Crisis Services Provider (B7)

Place of Service:
Inpatient Hospital (21)
Inpatient Psychiatric Facility (51)
Other (99)

Billing Unit: Per Diem

Billing Limitations

For crisis intervention services (stabilization) the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Crisis intervention services are limited to up to 23 hours per episode. After 23 hours in this crisis setting, the person, depending on his/her discharge plan, must be transferred and/or admitted to a more appropriate setting for further treatment (e.g., inpatient hospital, subacute facility, respite, etc.) or sent home with arrangements made for follow-up services, if appropriate (e.g., prescription for follow-up medications, in-home stabilization services).

3. If a client receives service code S9484 or S9485 at a Level I inpatient hospital or subacute facility, then the client is admitted to a Level I inpatient hospital or subacute bed in that same facility on the same day, the per diem Level I rate and code for the inpatient or subacute facility must be billed. S9484 or S9485 and an inpatient hospital per diem or inpatient subacute per diem code cannot be billed on the same date of service for the same client by the same provider.

4. Medical supplies provided to a person while in a crisis services setting and provided by the crisis service provider type are included in the rate and should not be billed separately.

5. Meals are included in the rate and should not be billed separately.

6. Transportation services are not included in the rate and should be billed separately using the appropriate transportation procedure codes.

7. Laboratory and radiology services are not included in the rate and should be billed separately.

8. Medications are not included in the rate and should be billed separately.

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II. E. 3. Crisis Intervention (Telephone)

General Information

General Definition

Crisis intervention (telephone) services provide triage, referral and telephone-based support to persons in crisis; often providing the first place of access to the behavioral health system. The service may also include a follow-up call to ensure the person is stabilized.

Service Standards/Provider Qualifications

The personnel for the crisis phone must include, at a minimum, behavioral health technicians supervised by a behavioral health professional. These individuals must be able to quickly assess the needs of the caller. While some situations may be resolved on the telephone, other situations may require face-to-face intervention in which case the telephone personnel must be able to ensure the provision of the most appropriate intervention (e.g., call 911, dispatch mobile team, referral to crisis intervention services.

Billing Information

When a service provider or clinical liaison provides crisis telephone services to an enrolled person, the provider should bill the appropriate case management service code.

II. F. Inpatient Services

Inpatient services (including room and board) are provided by an OBHL licensed Level I behavioral health agency and include the following subcategories:

- Hospitals
- Subacute Facilities
- Residential Treatment Centers (RTC)

These facilities provide a structured treatment setting with daily 24-hour supervision and an intensive treatment program, including medical support services.[5]

Service Standards/Provider Qualifications

Inpatient services may only be provided by OBHL licensed behavioral health agencies that meet the general Level I licensure requirements set forth in A.A.C. R9-20. In addition, depending on the type of services being provided, the facility may need to meet supplemental requirements as set forth in the licensing rules.

Institution for Mental Diseases (IMD)

Except for general hospitals with distinct units (Provider Type 02), all other Level I facilities with more than 16 beds (Provider Types 71, B1, B3, B6) are considered under Title XIX/XXI to be Institutions for Mental Diseases (IMDs). An IMD is defined under 42 CFR 435.1009 as an institution with more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and other related services.

IMD provider types 71 (Level I Psychiatric Hospital) and B6 (Level I Subacute Facility) are subject to the following coverage limitations:

- For Title XIX members age 21 to 64 years old, only 30 days per admission and 60 days per contract year (July 1st through June 30th) are covered. The 60-day limitation is cumulative and includes any emergency days provided by a Health Plan or other provider.
- Members who exceed this limit may lose their Title XIX eligibility.
- For Title XIX members age 0 – 20 years old and age 65 years and older there are no length of stay limitations beyond medical necessity.

[5]The following exception applies:
Based on behavioral health recipient needs, the following support services may be provided and billed on the same day that Level I services are provided:

- Self-help /Peer Services (H0038)
- Home Care Training Family Services (S5110)

The support services indicated above may be billed on the same day as inpatient services through a manual over-ride process. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

- A Title XIX eligible member who turns age 21 while receiving services in an IMD, may continue to receive this service until the service is no longer required or the person turns age 22 whichever comes first.
- For Title XXI (Kids Care) members there is no 30/60-day limitation. A person who is not currently eligible for Kids Care may not apply for services at admission or while in an IMD.

Please refer to Appendix F. Institutions for Mental Disease for further information about reporting, tracking, etc., requirements for facilities that are IMDs.

Code Specific Information

CPT Codes

Services provided in hospitals are inclusive of all services, supplies, accommodations, staffing, and equipment. CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to *Appendix B.2. – Allowable Procedure Code Matrix* to identify providers who can bill using CPT codes.

CODE	DESCRIPTION-Inpatient Services (Professional)
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient.
90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services.
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient.
90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services.
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient.

90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services.
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient.
90824	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services.
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient.
90827	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services.
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient.
90829	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services.
99217	Observation care discharge day management.
99218	Initial observation care, per day, for the evaluation and management of a patient which requires the three key components: a detailed or

	comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity.
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.
99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making that is straightforward or of low complexity. (Approx 30 min)
99222	Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making for a problem of moderate complexity. (Approx 50 min)
99223	Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. (Approx 70 min)
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 components: a problem-focused interval history; a problem-focused examination; medical decision-making that is straightforward or of low complexity. (Approx 15 min)
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of 3 components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision-making of moderate complexity. (Approx 25 min)
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of 3 components: a detailed interval history; a detailed examination; medical decision-making of high complexity. (Approx 35 min)

99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical-decision making of moderate complexity.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; comprehensive examination; and medical-decision making of high complexity.
99238	Hospital discharge day management; 30 minutes or less.
99239	Hospital discharge day management; more than 30 minutes.
99251	Initial inpatient consultation for a new or established patient, which requires 3 components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making for a minor problem. (Approx. 20 minutes)
99252	Initial inpatient consultation for a new or established patient, which requires 3 components: an expanded problem-focused history; an expanded problem-focused examination; and straightforward medical decision-making. (Approx 40 min)
99253	Initial inpatient consultation for a new or established patient, which requires 3 components: a detailed history; a detailed examination; and medical decision-making of low complexity. (Approx. 55 minutes)
99254	Initial inpatient consultation for a new or established patient, which requires these 3 components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. (Approx 80 min)
99255	Initial inpatient consultation for a new or established patient, which requires these 3 components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. (Approx 110 min)

99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Usually, the patient is stable, recovering or improving.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Usually, the patient has developed a significant complication or a significant new problem.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.
99356	Prolonged physician services in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour.
99357	Prolonged physician services in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes.

Revenue Codes

Except for crisis intervention services, all Level I inpatient behavioral health facilities must bill on a UB92 claim form or electronically through an 837I for an inpatient residential stay. Unlike other services in which a specific rate has been established for a

specific service code, the residential rates for these facilities have been established based on the provider type. For example, while a hospital and an RTC may both bill revenue code 0114, the fee-for-service rate will be different depending on the provider type billing the service.

HCPCS Codes

A licensed hospital, psychiatric hospital or subacute facility should use codes under category of service 47 (Mental Health) to bill for crisis intervention services provided in a crisis services setting in addition to the CPT codes for those services provided by certain health care professionals.

II. F. 1. Hospital

General Information

General Definition

Provides continuous treatment that includes general psychiatric care, medical detoxification, and/or forensic services in a general hospital, a general hospital with a distinct part or a freestanding psychiatric facility. Includes 24 hour nursing supervision and physicians on site and on call.

Service Standards/Provider Qualifications:

Hospitals may provide services to persons if the hospital is:

- -Accredited through The Joint Commission if providing treatment to clients under the age of 21; and
- -Meets the requirements of 42 CFR 440.10 and Part 482 and is licensed pursuant to A.R.S. 36, Chapter 4, Articles 1 and 2; or
- -For adults age 21 or over, certified as a provider under Title XVIII of the Social Security Act; or
- -For adults age 21 or over, currently determined by ADHS Assurance and Licensure to meet such requirements.

In addition, hospitals providing emergency inpatient services beyond 72 hours must have OBHL licensure.

Freestanding psychiatric facilities must meet the specific requirements of A.A.C. R9-20 (i.e., provision of psychiatric acute care). Additionally, if seclusion and restraint is provided, then the facilities must meet the requirements set forth in A.A.C. R9-20.

Code Specific Information

Revenue Codes:

Hospitals may bill the following revenue codes:

0114 – Psychiatric; room and board – private
0124 – Psychiatric; room and board – semi private two beds
0134 – Psychiatric; room and board – semi private three and four beds
0154 – Psychiatric; room and board – ward.
0116 – Detoxification; room and board – private
0126 – Detoxification; room and board – semi private two beds
0136 – Detoxification; room and board – semi private three and four beds
0156 – Detoxification; room and board – ward.

Billing Provider Type:
Hospital (02)
Psychiatric Hospital (71)

Billing Unit: Per Diem

Billing Limitations

1. Non-emergency travel time for a person in a hospital/psychiatric hospital is included in the rate and should not be billed separately.

2. Emergency transportation provided to a person residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

3. Medical services provided to a person while in a hospital/psychiatric hospital are included in the rate and should not be billed separately.

4. Medical supplies provided to a person while in a hospital/psychiatric hospital are included in the rate and should not be billed separately.

5. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials, are included in the rate and should not be billed separately.

6. Meals are included in the rate and should not be billed separately.

7. The revenue codes for hospital/psychiatric hospital services are billed per day for each person receiving services.

8. Medication provided/dispensed by the hospital/psychiatric hospital are included in the rate and cannot be billed separately.

9. Laboratory, Radiology and Medical Imaging provided by the hospital/psychiatric hospital are included in the rate and should not be billed separately.

10. The hospital/psychiatric hospital cannot bill for therapeutic leave/bed hold.

II. F. 2. Subacute Facility

General Information

General Definition

Continuous treatment provided in a subacute facility to a person who is experiencing acute and severe behavioral health and/or substance abuse symptoms. Services may include emergency reception and assessment; crisis intervention and stabilization; individual, group and family counseling; detoxification and referral. Includes 24 hour nursing supervision and physicians on site or on call. May include crisis intervention services that are provided in a crisis services setting licensed as a subacute facility but which does not require the person to be admitted to the facility.

Service Standards/Provider Qualifications:

Subacute facilities must be accredited by The Joint Commission, COA, or CARF and licensed by OBHL as a Level I facility meeting the specific requirements of A.A.C. R9-20. Additionally, the facilities must meet the requirements set forth in A.A.C. R9-20 for seclusion and restraint if the facility has been authorized by OBHL to provide seclusion and restraint.

Code Specific Information

Revenue Codes:

Level I subacute facilities may bill the following revenue codes:

0114 – Psychiatric; room and board – private
0124 – Psychiatric; room and board – semi private two beds
0134 – Psychiatric; room and board – semi private three and four beds
0154 – Psychiatric; room and board – ward.
0116 – Detoxification; room and board – private
0126 – Detoxification; room and board – semi private two beds
0136 – Detoxification; room and board – semi private three and four beds
0156 – Detoxification; room and board – ward.

Billing Provider Type:
Subacute Facility (IMD) (B6)
Subacute Facility (Non-IMD) (B5)

Billing Unit: Per Diem

Billing Limitations

1. See general core billing limitations in Section I.

2. The revenue codes for subacute facility services are billed per day for each person receiving services.

3. Non-emergency transportation time for a person in a subacute facility is included in the rate and should not be billed separately.

4. Emergency transportation provided to a person residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. Medical services provided to a person while in a subacute facility are included in the rate and should not be billed separately.

6. Laboratory, Radiology and Medical Imaging provided by the subacute facility are not included in the rate and should be billed separately. Laboratory, Radiology and Medical Imaging services related to a behavioral health condition are the responsibility of the T/RBHA.

7. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials are included in the rate and should not be billed separately.

8. Meals are included in the rate and should not be billed separately.

9. The following services are not included in the rate and may be billed independently if prescribed by a qualified provider: lab, radiology and psychotropic medication.

II. F. 3. Residential Treatment Center

General Information

General Definition:

Inpatient psychiatric treatment, which includes an integrated residential program of therapies, activities, and experiences provided to persons who are under 21 years of age and have severe or acute behavioral health symptoms. There are two types of residential treatment centers:

Secure - a residential treatment center which generally employs security guards and uses monitoring equipment and alarms.

Non-secure – an unlocked residential treatment center setting.

Service Standards/Provider Qualifications:

Residential treatment facilities must be accredited by The Joint Commission, COA, or CARF and licensed by OBHL as a Level I facility meeting the specific requirements of A.A.C. R9-20. Additionally, the facility must meet the requirements for seclusion and restraint set forth in A.A.C. R9-20 and in accordance with 42 CFR 441 and 483 if the facility has been authorized by OBHL to provide seclusion and restraint.

Code Specific Information

Revenue Code:

For inpatient stays the residential treatment center may bill the following revenue codes:

0114 – Psychiatric; room and board – private
0124 – Psychiatric; room and board – semi private two beds
0134 – Psychiatric; room and board – semi private three and four beds
0154 – Psychiatric; room and board – ward
0116 – Detoxification; room and board – private
0126 – Detoxification; room and board – semi private two beds
0136 – Detoxification; room and board – semi private three and four beds
0156 – Detoxification; room and board – ward.

Billing Provider Type:
Residential Treatment Center – Secure (Non-IMD) (78)
Residential Treatment Center – Secure (IMD) (B1)
Residential Treatment Center – Non-Secure (Non-IMD) (B2)
Residential Treatment Center – Non-Secure (IMD) (B3)

Billing Unit: Per Diem

Residential treatment centers may bill for bed hold days. These are days in which the RTC is reserving the person's space in the RTC in which he/she has been residing while the person is on an authorized / planned overnight leave from the RTC related to:

- Therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning (billed using revenue code 0183 – home pass) or
- Admittance to a hospital for a short stay (billed using revenue code 0189 – bed hold).

After the leave, the person is returned to the same bed within the RTC. Any combination of bed hold leave is limited to up to 21 days per contract year (July 1st through June 30th). The following revenue codes must be used to bill for bed hold days:

0183 – home pass
0189 – bed hold

Billing Provider Type:
Residential Treatment Center – Secure (non-IMD) (78)
Residential Treatment Center – Secure (IMD) (B1)
Residential Treatment Center - Non-Secure (non-IMD) (B2)
Residential Treatment Center – Non-Secure (IMD) (B3)

Billing Unit: Per Diem

Billing Limitations:

1. See general core billing limitations in Section I.

2. The RTC revenue code is billed per day for each person receiving services.

3. The RTC revenue code is a "bundled" rate that includes all HCPCS procedure code services an individual receives.

4. Expenses related to the person's education are not included in the RTC rate and, when applicable, should be billed separately.

5. Non-emergency transportation time for a person in a RTC facility is included in the rate and should not be billed separately.

6. Emergency transportation provided to a person residing in the RTC facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

7. Medical supplies provided to a person while in a RTC Facility are included in the rate and should not be billed separately.

8. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials, are included in the rate and should not be billed separately.

9. Meals are included in the rate and should not be billed separately.

10. Lab, radiology, medical imaging and psychotropic medications are not included in the rate and should be billed separately by qualified providers.

II. G. Residential Services

Residential services are provided on a 24-hour basis and are divided into the following subcategories based on the type of facility providing the services:

- Level II Behavioral Health Residential Facilities
- Level III Behavioral Health Residential Facilities

II. G. 1. Behavioral Health Short-Term Residential (Level II), Without Room and Board

General Information

General Definition

Residential services that are provided by an OBHL licensed Level II behavioral health agency. These agencies provide a structured treatment setting with 24-hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.

RBHAs must clearly set forth in provider subcontracts the type of services which are to be provided as part of the residential program, type of persons to be served, expected program outcomes, services which are included in the rate and those which can be billed outside the rate and documentation requirements.

Service Standards/Provider Qualifications

These services may only be provided by OBHL licensed behavioral health agencies that meet the general Level II licensure requirements set forth in A.A.C. R9-20.

Room and board is not covered by Title XIX/XXI for persons residing in level II therapeutic behavioral health residential facilities. (See service description on room and board.)

Code Specific Information

HCPCS Codes

- **H0018– Behavioral Health Short-Term Residential (Level II), without room and board:** See general definition above.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Level II Behavioral Health Residential Facilities (non-IMDs) (74)

  Place of Service:
  Other (99)

- Billing Unit: Per Diem

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II. G. 2. Behavioral Health Long-Term Residential (Non-medical, Non-acute) Without Room and Board (Level III)

General Information

General Definition

Residential services that are provided by an OBHL licensed Level III behavioral health agency. These agencies provide continuous 24-hour supervision and intermittent treatment in a group residential setting to persons who are determined to be capable of independent functioning but still need some protective oversight to insure they receive needed services.

Service Standards/Provider Qualifications

These services may only be provided by OBHL licensed behavioral health agencies that meet the general Level III licensure requirements set forth in A.A.C. R9-20.

Code Specific Information

HCPCS Codes

- **H0019 –Behavioral Health, Long-Term Residential Services (non-medical, non-acute), without room and board (Level III):** See general definition above.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Level III Behavioral Health Residential Facility (Non-IMD) (A2)

  Place of Service:
  Other (99)

  Billing Unit: Per Diem

Fee-For Service Rate Assumptions:

The AHCCCS/ADHS/DBHS fee-for-service rate for Behavioral Health Long-Term Residential Services (non-medical, non-acute), without room and board (Level III) is listed in Appendix B-2.

TRBHA fee-for-service claims will be paid at the fee-for-service rate as listed in Appendix B-2.

The RBHAs are expected to establish their own per diem rates for this service. The RBHA's provider contract for this service should clearly set forth the type of services which are to be provided as part of the residential program, type of persons to be served,

and services included in the rate. The rate may be different for individuals based on the acuity of each and necessary staffing adjustments.

The rates must include the following:

1. All staff who cannot bill CPT codes
2. Supervisions of staff by those billing CPT codes
3. All non-emergency travel
4. Non-legend drugs and non-customized medical supplies

Room and board is not covered by Title XIX/XXI for persons residing in Level III behavioral health residential facilities. (See section on service description of room and board.)

II. G. 3. Mental Health Services NOS (Room and Board)

General Information

General Definition

Room and board means provision of lodging and meals to a person residing in a residential facility or supported independent living setting which may include but is not limited to: services such as food and food preparation, personal laundry, and housekeeping.

Service Standards/Provider Qualifications

The provider must meet the following requirements:

- Provide safe and healthy living arrangements that meet the needs of the person and
- Provide or ensure the nutritional maintenance for the resident.

Code Specific Information

State Funded HCPCS Codes

- **H0046 SE – Mental Health Services NOS (Room and Board):** See general definition above.

  Billing Provider Type:
  RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Level II Behavioral Health Residential Facilities (Non-IMDs) (74)
  Outpatient Clinics (77) – restricted to Supervised Independent Living program services
  Level III Behavioral Health Residential Facility (A2)
  Community Service Agency (A3)
  Behavioral Health Therapeutic Home (A5)
  Rural Substance Abuse Transitional Agency (A6)
  Other (S2)

  Place of Service:
  Other (99)

  Billing Unit: Per Diem

Billing Limitations

For room and board services, the following billing limitations apply:

All other fund sources (e.g., DES funds for foster care children, SSI) must be exhausted prior to billing this service. Outpatient Clinics may bill the Room and Board code only when providing services to persons in Supervised Independent Living settings.

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II. H. Behavioral Health Day Programs

Behavioral health day program services are scheduled on a regular basis either on an hourly, half day or full day basis and may include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance abuse programs. These programs can be provided to a person, group of persons and/or families in a variety of settings.

Based on the level / type of staffing, day programs are grouped into the following three subcategories:

- Supervised
- Therapeutic
- Psychiatric/Medical

RBHAs must clearly set forth in provider contracts the type of services which are to be provided as part of the behavioral health day program, type of persons to be served, expected program outcomes, documentation requirements and services which are included in the rate and services that are billed outside the rate.

II. H. 1. Supervised Behavioral Health Treatment and Day Programs

General Information

General Definition

A regularly scheduled program of individual, group and/or family activities/services related to the enrolled person's treatment plan designed to improve the ability of the person to function in the community and may include the following rehabilitative and support services: skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, and self-help/peer services.

Service Standards/Provider Qualifications

Supervised behavioral health treatment and day programs may be provided by either OBHL licensed behavioral health agencies or Title XIX certified community service agencies. The individual staff that deliver specific services within the supervised behavioral health treatment and day programs must meet the individual provider qualifications associated with those services. Supervised behavioral health treatment and day programs provided by non-OBHL licensed community service agencies must be supervised by a behavioral health technician or behavioral health para-professional.

Code Specific Information

HCPCS Codes

- **H2012 –-Supervised Behavioral Health Day Treatment:** See general definition above. Per hour up to 5 hours in duration.

  Billing Provider Type:
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Community Service Agency (A3)

  Place of Service:
  Community Mental Health Center (53)
  State or Local Public Health Clinic (71)
  Rural Health Clinic (72)
  Other (99)

  Billing Unit: Per hour

- **H2015 – Comprehensive Community Support Services (Supervised Day Program):** See general definition above. Greater than 5 hours up to 10 hours in duration.

  Billing Provider Type:
  T/RBHA (72)
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)
  Community Service Agency (A3)

  Place of Service:
  Community Mental Health Center (53)
  State or Local Public Health Clinic (71)
  Rural Health Clinic (72)
  Other (99)

  Billing Unit: Per 15 minutes

Billing Limitations

For supervised day programs and treatment, the following billing limitations apply:

1. See general core billing limitations in Section I.

2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.

3. Meals provided as part of the supervised day treatment are included in the rate and should not be billed separately.

4. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

II. H. 2. Therapeutic Behavioral Health Services and Day Programs

General Definition

A regularly scheduled program of active treatment modalities which may include services such as individual, group and/or family behavioral health counseling and therapy, skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, home care training family (family support), medication monitoring, case management, self-help/peer services, and/or medical monitoring.

Service Standards/Provider Qualifications

Therapeutic behavioral health services and day programs must be provided by an appropriately licensed OBHL behavioral health agency and in accordance with applicable service requirements set forth in A.A.C. Title 9, Chapter 20. These programs must be under the direction of a behavioral health professional. The individual staff persons who deliver the specific services within the therapeutic day program must meet the individual provider qualifications associated with those services.

Code Specific Information

HCPCS Codes

- **H2019 – Therapeutic Behavioral Services (Day Program):** See general definition above. Up to 5 ¾ hours in duration.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Community Mental Health Center (53)
  Level I Psychiatric Hospital (IMD) (71)
  Rural Health Clinic (72)
  Other (99)

  Billing Unit: 15 minutes

- **H2019 TF – Therapeutic Behavioral Services (Day Program):** See general definition above. Up to 5 ¾ hours in duration. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

Billing Provider Type:
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)

Place of Service:
Community Mental Health Center (53)
Level I Psychiatric Hospital (IMD) (71)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H2020 – Therapeutic Behavioral Health Day Services:** See general definition above.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Community Mental Health Center (53)
  Level I Psychiatric Hospital (IMD) (71)
  Rural Health Clinic (72)
  Other (99)

Billing Unit: Per Diem

- **H2019 TF – Home Therapeutic Behavioral Services (Day Program):** See general definition above. Up to 5 ¾ hours in duration. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Home (12)

  Billing Unit: 15 minutes

- **H2020 -- Home Therapeutic Behavioral Services (Day Program):** See general definition above.

Billing Provider Type:
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)

Place of Service:
Home (12)

Billing Unit: Per Diem

Billing Limitations

For therapeutic behavioral health services and day programs, the following billing limitations apply:

1. See general core billing limitations in Section I.

2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.

3. A registered nurse who supervises therapeutic behavioral health services and day programs may not bill this function separately. Employee supervision has been built into the procedure code rates.

4. Meals provided as part of therapeutic behavioral health services and day programs are included in the rate and should not be billed separately.

5. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

II. H. 3. Community Psychiatric Supportive Treatment and Medical Day Programs

General Definition

A regularly scheduled program of active treatment modalities, including medical interventions, in a group setting. May include individual, group and/or family behavioral health counseling and therapy, skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, home care training family (family support), and/or other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

Service Standards/Provider Qualifications

Community psychiatric supportive treatment and medical day programs must be provided by an appropriately licensed OBHL behavioral health agency and in accordance with applicable service requirements set forth in A.A.C. Title 9, chapter 20. These programs must be under the direction of a licensed physician, nurse practitioner, or physician assistant. The individual staff persons who deliver the specific services within the supervised day programs must meet the individual provider qualifications associated with those services.

Code Specific Information

HCPCS Codes

- **H0036– Community Psychiatric (Medical) Supportive Treatment Day Program, Face-to-Face:** See general definition above.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Community Mental Health Center (53)
  Rural Health Clinic (72)
  Other (99)

  Billing Unit: 15 minutes

- **H0036 TF– Community Psychiatric Supportive Treatment Medical Day Program, Face-to-Face:** See general definition above. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

Billing Provider Type:
Out-of-state, One Time Fee For Service Provider (73)
Outpatient Clinic (77)

Place of Service:
Community Mental Health Center (53)
Rural Health Clinic (72)
Other (99)

Billing Unit: 15 minutes

- **H0036 – Home Community Psychiatric Supportive Medical Treatment, Face-to-Face:** See general definition above.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Home (12)

  Billing Unit: 15 minutes

- **H0036 TF – Home Community Psychiatric Supportive Medical Treatment, Face-to-Face:** See general definition above. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Home (12)

  Billing Unit: 15 minutes

- **H0037– Community Psychiatric Supportive Treatment Medical Day Program**: See general definition above.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

Place of Service:
Community Mental Health Center (53)
Rural Health Clinic (72)
Other (99)

Billing Unit: Per Diem

- **H0037– Community Psychiatric Supportive Treatment Medical Day Program**: See general definition above.

  Billing Provider Type:
  Out-of-state, One Time Fee For Service Provider (73)
  Outpatient Clinic (77)

  Place of Service:
  Home (12)

  Billing Unit: Per Diem

Billing Limitations

For community psychiatric supportive treatment and medical day programs, the following billing limitations apply:

1. See general core billing limitations in Section I.

2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.

3. Meals provided as part of community psychiatric supportive treatment and medical day programs are included in the rate and should not be billed separately.

4. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

II. I. Prevention Services

General Information

General Definition

Prevention services promote the health of persons, families, and communities through education, engagement, service provision and outreach. These services may involve:

-Implementation of strategic interventions to reduce the risk of development of emergence of behavioral health disorders, increase resilience and/or promote and improve the overall behavioral health status in targeted communities and among individuals and families;

-Education to the general public on improving their mental health and to general health care providers and other related professionals on recognizing and preventing behavioral health disorders and conditions;

-Identification and referral of persons and families who could benefit from behavioral health treatment services.

Prevention services should target conditions identified in research that are related to the on-set of behavioral health problems and be provided based on identified risk factors, the extent that the problem occurs in the community or target group, identified community needs and service gaps within each RBHA area. Prevention services should target communities, neighborhoods, and audiences who are at elevated risk for developing behavioral health disorders.

These services are generally provided in a group setting or public forum setting and are intended to target individuals and families who are not enrolled or involved in the ADHS/DBHS treatment system and who do not have a diagnosable behavioral health disorder or condition. Prevention services are not intended for individuals and family members requiring treatment interventions or for family members of an enrolled member.

Strategy Specific Information

The following strategies shall be used for services described in this section.

-Public Information on Substance Abuse and Mental Health: Public presentations of electronic, verbal and printed promotional material on preventable substance abuse and mental health disorders.

-Prevention Training to Professionals: Training provided to Behavioral Health or other prevention professionals on prevention concepts, strategies and activities with the purpose of enhancing the preventionist's skills, thereby improving the quality of

prevention programs. May include training of trainers or professional seminars, and must include goals and objectives based on a training needs assessment.

-Community Education: Sequential educational sessions provided to a targeted group to promote change in unhealthful attitudes and behaviors.

-Parent/Family Education: Sequential educational sessions provided to parents and their family members to improve parenting and to promote healthy family functioning.

-Community Activities for At Risk Populations: Supervised alternative leisure/free time activities to enrich community opportunities for youth, families and adults at risk for the emergence or development of behavioral health disorders.

-Community Mobilization: Assistance to communities in the development of local conditions and community plans to address community conditions and behavioral health issues, in accordance with an approved community needs assessment. Includes development of partnerships, assistance with planning, identification of needs, resources and strategies and ongoing training and technical assistance.

-Life Skills Development: Sequential educational sessions that assist individuals in developing or improving critical life skills, such as decision-making, coping with stress, values awareness, resistance skills, problem solving and conflict resolution.

-Peer Leadership Skills: Leadership skills development through the pairing of trained and supervised peers with others. Must have curriculum; may include a variety of activities designed to reinforce leadership capabilities.

-Mentorship: Use of mature role models to provide support and guidance to youth and adults at risk for the development or emergence of behavioral health disorders, through the establishment and maintenance of positive personal relationships.

Service Standards and Provider Qualifications

Prevention services may be provided by a variety of qualified prevention professionals, including but not limited to behavioral health technicians, behavioral health para-professionals, public health specialists, and educators. These individuals must have documented training in prevention theory and practice and demonstrate qualifications for the specific strategy and service delivered.

Billing Limitations

Reimbursement for these services is restricted to monies available to the state from the Federal Substance Abuse Prevention and Treatment Block Grant (SAPT) and other applicable state-funded appropriations and as such must be provided in accordance with limitations set forth by the applicable funding source. Prevention programs and services shall comply with ADHS/DBHS guidelines as described in the Prevention Framework for Behavioral Health.

Reimbursement

Prevention services are those services that are contracted through a Regional Behavioral Health Authority. Contracts for prevention services shall specify the scope of work to be performed, duration and dosage of the prevention strategy to be delivered, number of participants to be served, evaluation methods to be used, specific reporting requirements and method and amount of payment for satisfactory completion of services, among other provisions. Encounters are not submitted for prevention services.

III. Appendices

A. Reserved

B. Reference Tables

B-1. Reserved

B-2. ADHS/DBHS Allowable Procedure Code Matrix

B-3. HIPAA Code Crosswalk

B-4. Reserved

B-5. Billing Limitations Matrix

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C. Related Information Resources

D. Reserved

D.1. Reserved

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F. Institution for Mental Diseases Information Sheet

G. Reserved